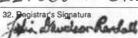
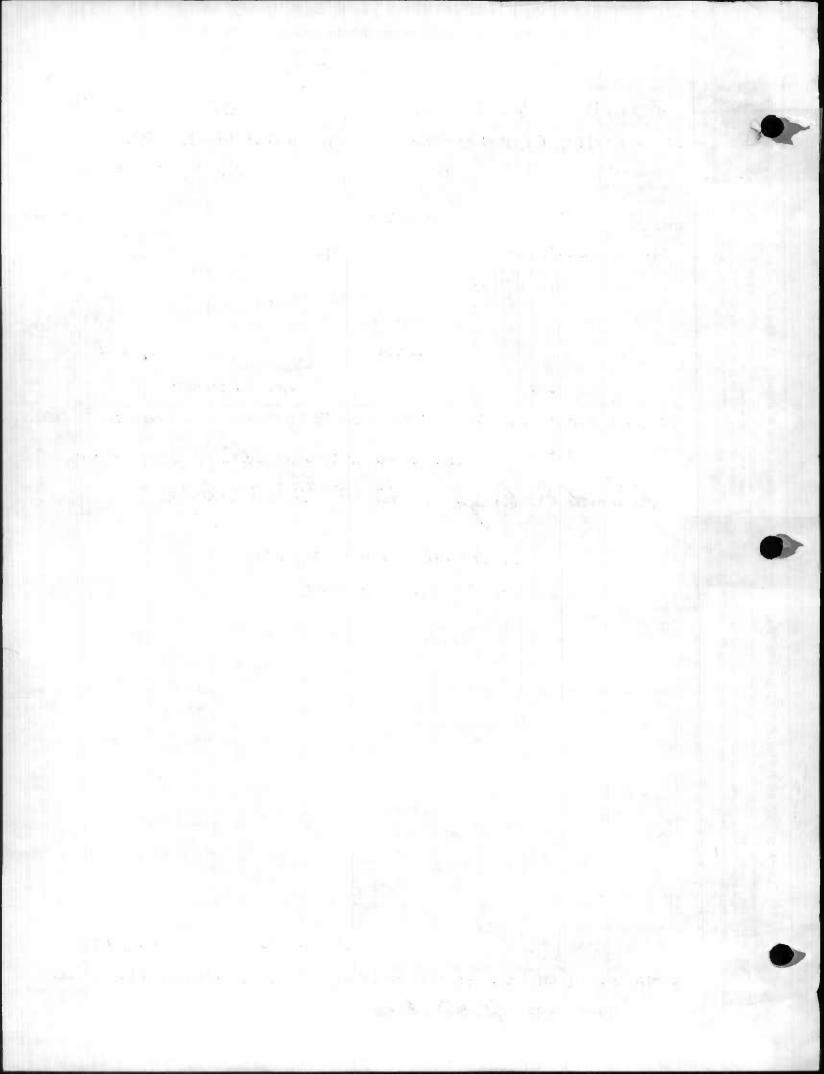
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yaar **Physician** 1435 Sperrazza Joseph Sperr 4a Facility Nama (Il not institution, giva street and number) 98 2 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner OF MARYLAND HOSPITAL BALTIMORE City UNIVERSIT 8. Data of Birth (Month, Dey, Year)
July 11, 1920 New York If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthpleca (Stata or Foreign **Funeral** Days Months 1 XM 2 F Hours 060-12-4767 77 Director Usual Rasidance of Decedant filed within 72 hours efter death with the Meryland 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Harford Whiteford Directo Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4748 Flintville Road 21160 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 20000 Was Decadant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Nevar Married 2 ☑ Married altimore. Maryland 21215-0020 1 Yas 25 No Spacify. If Yas, Giva Yaar or Datas: Specify: White à 3 Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry 1 Collaga (1-4or 5+) A Hygiene. Elamantary/Secondary (0-12) 12 U.S. Government Pages 1 end 2 should be filed witnest of Heelth end Mentel Hygien land: If item 27 is marked other theury or other traumatic avent, the Engineer 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Salvatore Sperrazza Angela Castallana 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10880 Pinewalk Forest Circle, Alpharetta, GA 30022 Joseph S. Sperrazza (Son) 20b. Placa of Disposition (Nama of cematary, crametory or other placa) 20c. Location - City or Town, State 20a. Mathod of Disposition Data Holy Sepulchre Catholic Cemet. 1 Burial 2 □ Crametion 3 Ramoval from Stata Department Inportant: If any Injury or once. Coram, New York 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Funetal Sarvice Licensaa Gar Pert 1. Enter tha disaasa, or complications that cayfed the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on again line. Approximate Intarval Batween Onsat and Death **Physician** /Medical Immediate Cause (Finel heart Ischemic disaasa or condition rasulting in daath) Examiner Examiner e renal that the death certificete be executed physician end s the buriel-transit Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or Injury that initiated avents rasulting in daath) Last Dua to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequance of) ettending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? been signed by t should be detect 1 Yes 2 No 3 Probably 4 Unknown Records, þ lew requires Completed 24b. Were autopsy findings aveileble prior to 24e. Wes an autopsy performed? complation of causa of death? page 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Attending Physician: director Be 25. Was casa refarred to medical 26. Place of Deeth (Check only one) Hospital: 1 Mainpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidanca 8 Other (Specify) LO 1 Yas 2 No After this 28a. Data of Injury (Month, Day Year) 27. Mennar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 Natural 5 Pending invastigation tnjury deeth. 1 Yas 2 No 2 Accidant ector: 6 Could not be determined 3 Suicida in by t 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) ofter 4 ☐ Homicida Hospital or To the Hospital within 24 hours o To the Funeral C edical 29a. Certifiar 1 🗹 Certifying Physician: To tha best of my knowledga, daath occurred at the time, dete and place, and dua to the causa(s) and mannar as statad. completely 2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and mannar stated. 29b. Signatura and titla of certifiar. 29c. Licansa number 29d. Date signed (Month, Day, Year) P11764 6/21/98 30. Nama and address of person, no completed cause of deeth (Itam 23a) (Type, Print) 22. SOUTH GREENE ST, BALTIMORE, MD 21201 SAPNA KUEHI, MD

State Registrar 31. Data filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 98 21002

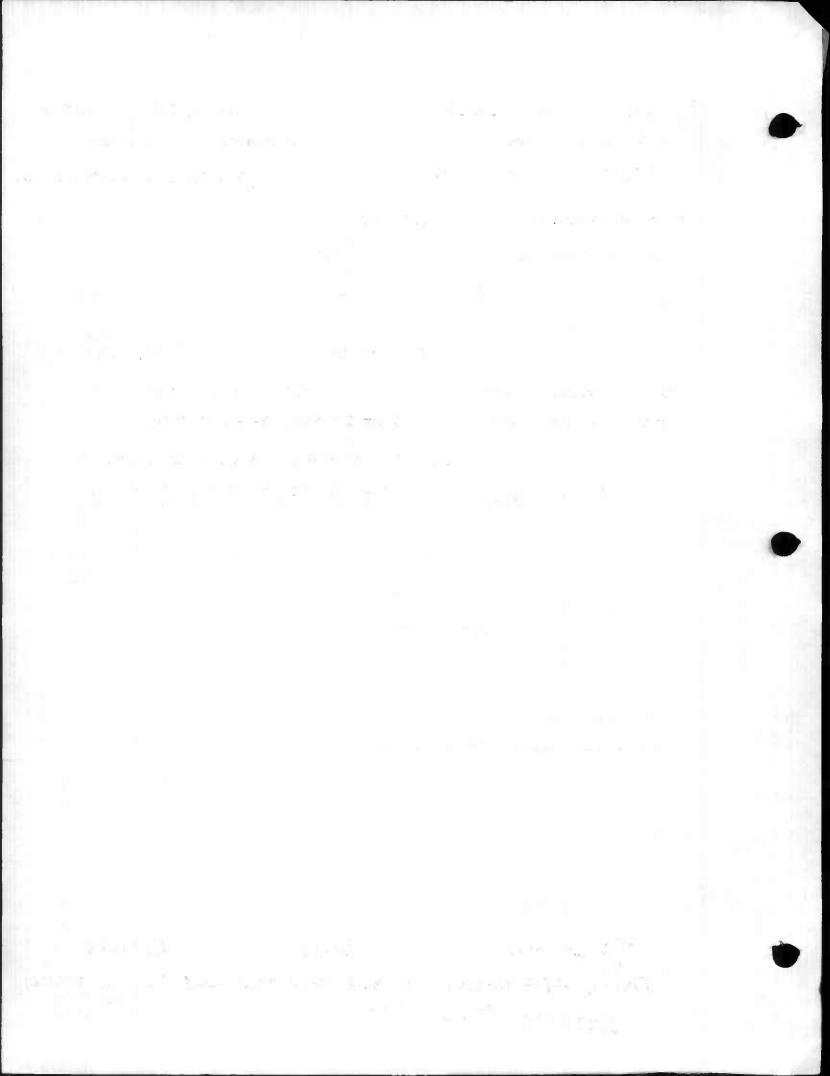
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with the	Director	10e. Street end Number 2234 Coralthorn	Pond			10f. Zip Code	220		10g. Citizen of V		ntry?
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elth and Mental Hygiene. 27 le marked other than or traumatic event, tra l	101	James Corbett 19a. Informant's Name/Reletionship Linda L. Waitkus		-		_	Ruth tand Number or R Road, Jo		Irwir or, City or Town, 21085		c Code)
permit. Pages 1 and 2 s Department of Health at Important: if item 27 le any injury or other trau once.		20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Othar (Speci		State Cer	metery, crei	sition (Neme of matory or other ple L1 Memor:	ial Gar.	Dete 6/22/98	20c. Location - Baltin		
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fler this	0	exeminer? 1 Yes 2 No 27. Menner of Death 1 Adurai 5 Pending	28e. Dete (Mon		R/Outpatier 28b. Time o Injury	28c. Inju	her: 4 Nursing I	Home 5 P Resid	lence 6 Oth		(y)
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() State		30. Name and eddress of person who TA/2/ 0 A	completed caus		131	Print) Back R	3725 Liver Ne	ick Rua	6/1 d Bult	mure	8 MD2/2

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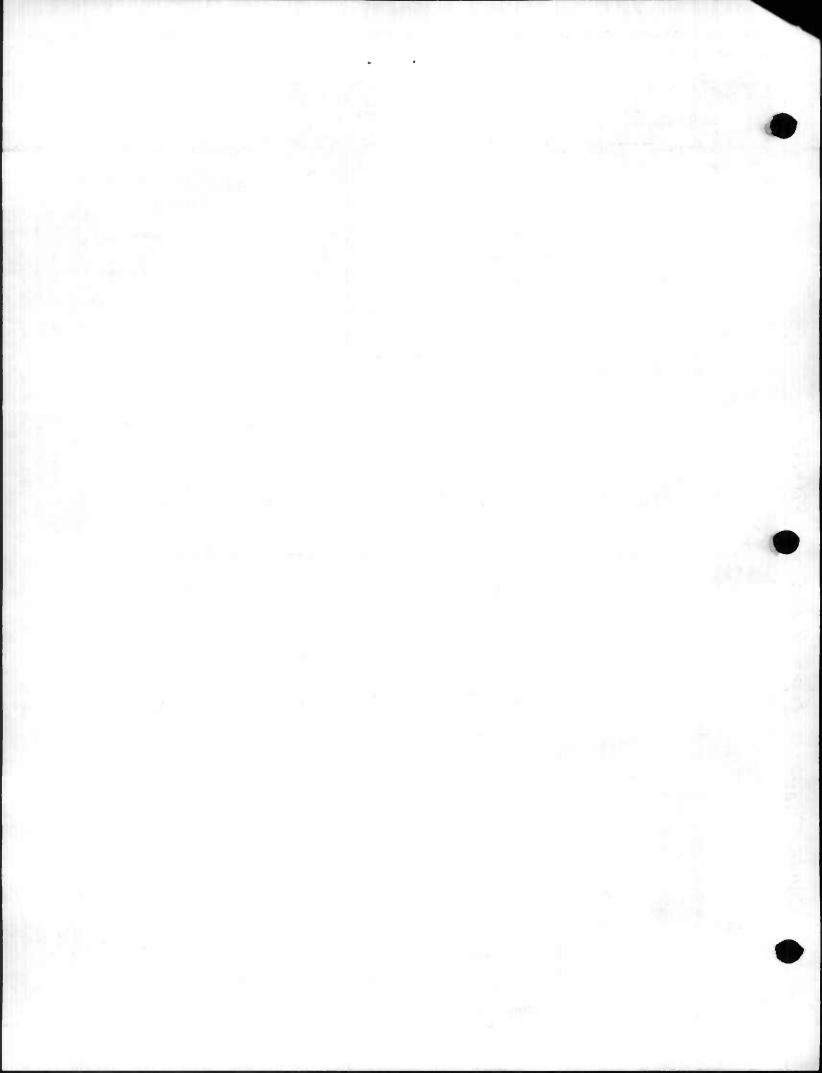
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	Physic /Medi		Decedent's Name (First, Middle, Last) Charles Edg	ar Slu	der				2. Data of De Month June	Day	Year 998	3. Time of Death
	Exami	ner	4a. Facility Name (If not Institution, give s Harford Memorial		1			4b. City, Town, or Havre	de Grace		of Death ford	
	Funeral Director		213-52-5021	7. Ag	e (In yrs. last 49		If Under 1 Yea Months Day			o, 1948	9. Birthplac Country Mary	e (State or Foreign Land
	ith the Maryland or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Harford	l	10c. City, To	own or Local			3071		10d	. Inside City Limits
	th with the 23a or 28	Funeral Director	10e. Street and Number 25 N. Philadelphia	Blvd.			10f. Zip Code 2100			10g. Citizen of V.S.		?
020	or items	by	11. Marital Status 1 □ Navar Marriad 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Armed Forces? 1 Types 2 1 If Yes, Give Year or Dates	No		s Decedent of es, specify Cu Yes 2 N	Hispanic Origin? (uban, Mexicen, Pue o Specify:	Specify Yes or Norto Rican, etc.)	o- 14. Rac Blac Specify	e - American ck, White, etc	
1215-0	filed within 72 hours Hygiane. ther than "natural", ant, the Medical Ex	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondery (0-12)	cation complated) College (1-4or 5	5+)			upation le during most of wo red)	orking	16b. Kind of Bi		
land 2	e, Maryla I and 2 should lealth and Men m 27 la marks her traumatic		12 17. Father's Name (First, Middle, Last) Fred Sluder	0		servic	e Dept	18. Mother's Na	Car Dealersh Car Dealersh Car Dealersh Car Dealersh Car Dealersh Car Dealersh Car Dealersh			.p
			19a. Informant's Name/Ralationship (Ty) Constance L. Sluce		se)	25 N.	Phila.		Aberdeen	, MD 21	001	
16/98 Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			el Hil	on (Name of lory or other p	etery	Date 6/19/98	Havre		
6/16/98 Baltimore	Depar Impor any in		21. Signatura of Funaral Service License Burskn Anu	Migu	les be	Tar Abe	ring-C erdeen,	lress of Facility Cargo Fund Maryland	d 21001	-3399		
•	Physician /Medical Examiner		23a. Part1. Enter the disaasa, or comble shock, or heart failure. List only on timmediete Ceuse (Final disease or condition resulting in deeth)	cations that coulsed e cause on each if	tha death. D	LOW	tha mode of d	\cap	ac or respiratory		In	pproximate iterval Between inset and Death
3/6	Jied Insit	Examiner	b	ter	Due to (or as	al i	Coles	n Cano	moni	er.		
4 @ /2 68760,	ficate be executed physician and as the burial-transit	edical Exa	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury the Initieted events resulting in death) Last		Due to (or as						1	
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B.O. 9.	that tha d ed by the detached	by Physician/M	Part II. Other significant conditions con	tributing to death b	ut not resulting	g in the unde	erlying cause	given in Pert I.		Yes 2	ritributs to ti	he cause of death bly 4 Unknow
les Records,	law requires as been sign 2 should be	Completed b	lugeters	700					24e. We	s en autopsy ormed?	avalla	autopsy findings able prior to pletion of cause ath?
AR H	The ate h	Be Con	25. Was case referred to medical					26. Plece of D	1 □ eath (Check only	Yes 2 00	101	fes 2□ No
€ 5	5 00	To	examiner?	ospitel: patie		Outpatient	3LI DOA		Home 5□Res	idence 6 Doth	er (Specify)	
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5	o the Hospital or Attending Phithin 24 hours after death. o the Funeral Director: After this mpletaly filled in by the funeral	Medical (29a. Certifier (Check only one) Certifying Phys	Iclan: To the best er: On the bests of and manner sta	examinetion	ige, deeth o end/or inves	ccurred et the stigetion, in my	time, dete end pled y opinion, death occ	ce, end due to the curred at the time	ceuse(s) end ma , date and plece,	anner as stal and due to th	ed. ne cause(s)
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24+1 State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Dey 15 Walter Francis Scott 06 1998 11 PW 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 1 X M 2□ F Months Min Deys Hours 215-09-5004 93 10/13/1904 Washington, DC Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 557 Green Street 21078 USA 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 M No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th Oil Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Walter Francis Scott, Sr. Anna Peine 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Virginia Lee Walters-Daughter 54 Woodhaven Ln Willingboro, NJ 08046 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Guriei 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Harford Memorial Gardens 6/19/98 Aberdeen, W.D. 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Mitchell-Smith Funeral Home, P.A. AUMC 123 S. Washington St. Havre de Grace N.D 21078 23a Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete intervei Between Onset end Deeth Immediate Cause (Fine! diseese or condition resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence Due to (or es e consequence of): 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 24e. Was en eutopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospital: pnpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 254 No 28e. Dete of Injury (Month, Day Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

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d other than "natural", or items 23a or 28a-1 show event, its Medical Evanier must be notified at

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Physician/Medical þ Completed certificate Be 2 After this Certification:

the death certificate be executed P.O. Box 68760. Division of Vital Records. filled in by the funeral Attending death. efter death 6 Hospital hours Funeral To the How within 24 h To the Fur

> State Registrar

Medicai

29b. Signature end title of certifier

Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 25. Was case referred to medical 1 Yes 27. Memher of Deeth 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) end manner steted.

d cause of death (Item 23a) (Type

29d. Date signed (Mente) Day, Year) 161

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Month Gerald Vernon Schnepf June 22 1998 6:40pm /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1**∑**M 2□ F Days Hours Yrs. 68 721-05-9398 1930 Minnesota Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 150 Bloomsbury Avenue USA 21078 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1951-53 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Saw Operator Chemical Company 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl August Schnepf Wartha Justine Schimnowski 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Norma Schnepf- Wife 150 Bloomsbury Ave. Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 CIBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/29/98 Pipestone Co., Winn. Woodstock Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD 21078 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth MYOGROVAL INCHEC Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequenca of) Physician/Medical thet initieted events resulting in deeth) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 No 1 Yes RONO 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpetlent 3 DOA 28a. Date of Injury (Month, Day Year) Menner of Death 28c. Injury at Work? 26d. Describe how Injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end manner as stated. edical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) 29b. Signature and title of g 30. Name and address of pe 31. Date filed (North

State Registrar

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic svent, the Medical Examiner must be not fred at

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permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once.

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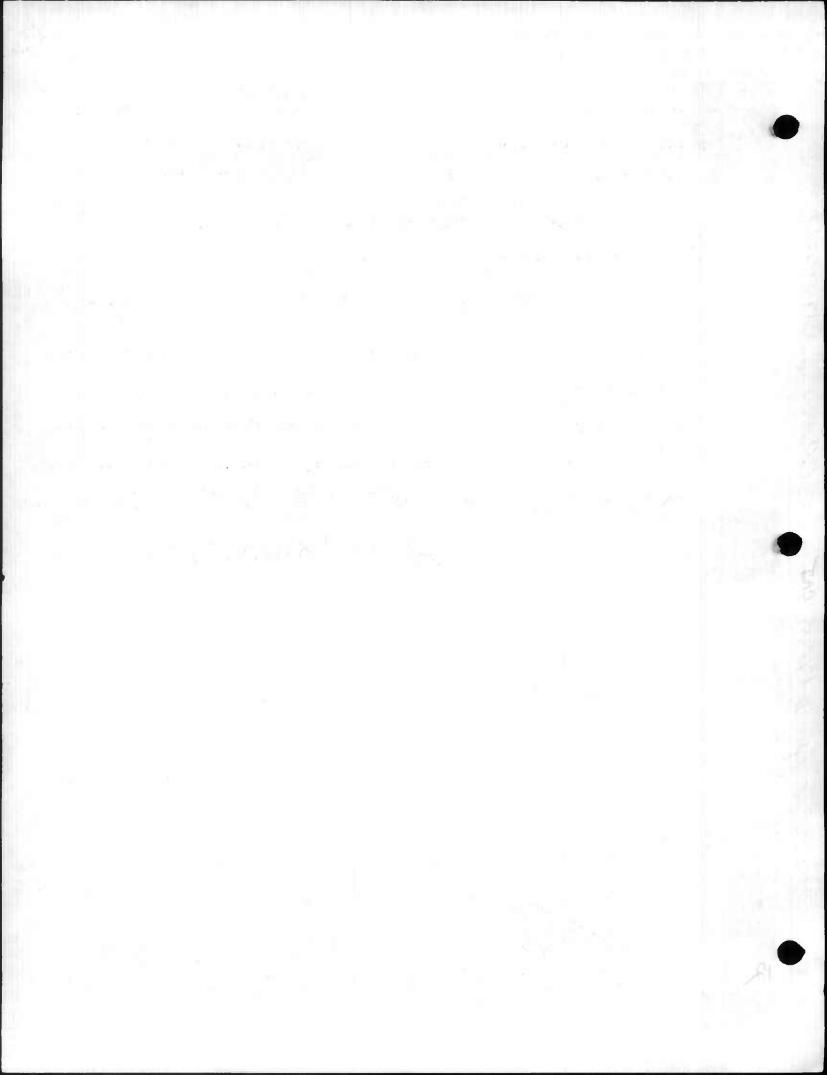
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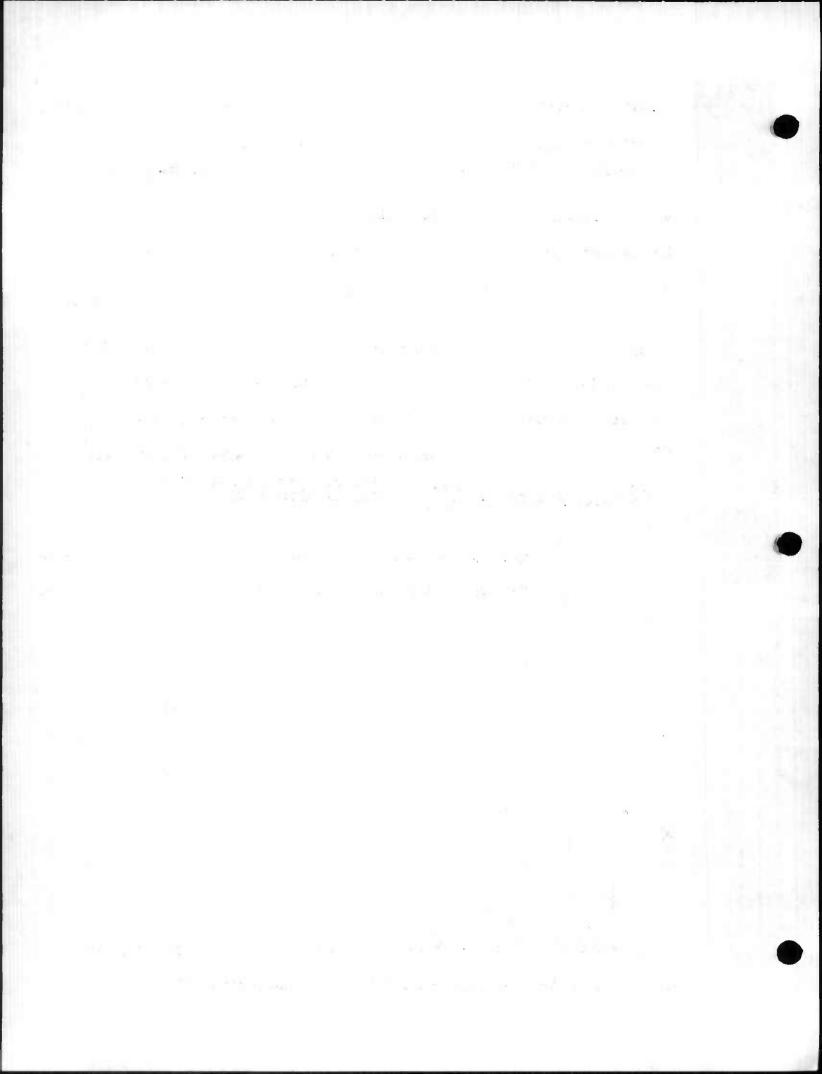
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		$-\Gamma$	1. Decedent's Neme (First, Middl	e, Last)			1: "				2. Dete of Dee	th	4650	3. Time of Deeth	1
	Physic		Patri	cia	L	Su	tton				June Month	22 1	998	1000	
	/Medi Exami		4e. Facility Neme (If not institution	n, give street end num	nber)				4b. City, To		cation of Deeth	4c. County			
L			The Kent and Qu		S HOSP			r 1 Year	Ches				nt	lana (Chaha an Fara)	la-
	Funeral Director		214-32-6087 Usuel Residence of Decedent	1□M ¾QXF	6.		Months		Hours	Min.	January L	Year)	Coun	lece (Stete or Foreighty) Ch Hill,	-
	wo m		10e. Stete 10b. County		10c. Ci	ty, Town or L	ocation						1	0d. Inside City Limit	ts
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	h the	Director	10a. Street end Number				10f. Zij	Code			1	0g. Citizen of	Whet Coun	try?	
	h wit	a D	7323 Remington	Drive				2162	:0			U.S.	Δ		
	dea	Funeral	11. Maritel Stetus	12. Wes Deced	dent Ever in U	,S. 13.	Was Dece	dent of h	lispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		ce - Americ		
21215-0020	n 72 hours efter death with the Maryland "naturel", or Items 23s or 28s-f show edical Examiner must be notified at	by	1 ☐ Never Married 2X Men 3 ☐ Widowed 4 ☐ Divorced		2 No		1 ☐ Yes		Specify:	, , , ,	riouri, oto.)	Specif			
5	72 h	etec	15. Deceden (Specify only higher			18e. Dece	dent's Usu	el Occup	etion during mosi d)	t of worki	ina	16b. Kind of B	usiness/Inc	lustry	
121	d within 72 ho piena. r than "natur r a Medicul	Completed	Elementery/Secondery (0-12)	College (1-	4or 5+)										
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e,	Haalth Haalth tam 27		20a. Method of Disposition		20b. F	Plece of Dispo	osition (Ne	ne of		terto	wn, MD 2	20c. Location	- City or To	wn, Stete	
90	ant of		TS Buriel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S)		tate	Dougle			,	l Heli	05 10	00 /01			
Baltimore,	permit. Peges 1 en Department of Haal Important: If item 2 any injury or other once.		21. Signature of Funeral Service	Licensee	1	Fo	2. Name e	Hold	ss of Fecilit	y S. N	ne 25, 19 Ewnam Fun	oval IIou			
_			23e. Perti. Enter the disease, or shock, or heert failure. List	Here	fer	13	O Spec	r Ros	d. Che	stert	own. MD	21620	е, г.А		
			shock, or heert failure. List	only one chise on ea	used the deat ich line.	n. Do not en	ter the mod	te of dyn	ng, such es	cardiac d	or respiretory err	est,		Approximete Intervel Between Onset end Deeth	
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ó	an an rial-tr		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury	WIL	1260T	1000	W-0	-	do		eft grea oun to	luna	3-47		
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Vital	ysician: The is certificata director, pag	Be	25. Wes case referred to medical examiner?	Hospitel:				Oth		of Deeth	(Check only or	10)			-
0	this ral di	-T	1 Yes 2 No 27. Manper of Deeth	1 28a. Dete of		ER/Outpetle		JA	4LI NU		me 5 Reside)	
	After fune	Fon	1 ☑Naturel 5 ☐ Pendin	g (Month	Dey Year)	Injury	M	28c. fnju Wo	k? Yes 2⊡I		200. Describe III	ow injury occur	ned .		
S	or Attending after death. Director: Afte I in by the func	lica	3 ☐ Sulcide 6 ☐ Could i	not be	of Injury - At h	ome form et	- 60		103 20		28f Location (S	treet and Num	her or Rura	l Route Number,	-
Division	after Direct	Certification:	4 ☐ Homicide determ	building	g, etc. (Specif	y)	166(, 120(0)	y, omos		1	City or Town		oor or ridia	riodie ridinoer,	
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completaly filled in by the	edical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the b Examiner: On the bas	is of exemine	wledge, deet	h occurred vestigetion	et the tir	ne, dete en	d plece, e	end due to the c	euse(s) end m ate and plece,	enner es st	ated.	-
	the the omple	Me	29b. Signeture end title of certifier	end menne	er steted.		29	: Licens	e number		2	9d. Date signe	d (Month	Day Year)	
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•		15	30 Name and seed	who completed	of death for	0000	Dale 1)	- 3	00/			0 123	148		
		レブ	30. Name and address of person of the Communication of the Archard of the state of	Who completed cause	WB 9	745 WH	Shing	For	Ave	, ch	rtenton	n, We	dz	1620	
	Sta Registi		31. Dete filed (Month, Day, 107)	24 '98 ^{32. Ro}	gistrar's Age	a Davids	n- Pan	delle							

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State of Maryland / Department of Health and Mental Hygiene

		Decedant's Nam	a (First Middle I.	ast)		Ce	ertificate	of	Death	P. Data of Dea	Reg. No.	18	3, Tima of Dec
Physicia	an		E. Spich							Month	Day	Yaar	
/Medica				va straat and number	ar)			-	4b. City, Town, or I		6, 1998 4c. County		6:38
Examine	er				21/								
	-	5. Social Security N	al Hospit		Ane (in ure	last birthday	/) If Undar 1	l Yaar	Cumber			legar	
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23a or 2	al Dire	10e. Streat and Nu 603 Gre	^{mbar} enway Av	enue			10f. Zip (00da 150	2		log. Citizan of t		ntry?
Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, its Medical Examinat must be notified at once.	y Funeral Director	11. Marital Status 1 Navar Marr 3 Widowad	ied 2 Marriad	12. Was Daceda Armed Force 1 Yas 2f If Yas, Giva	s? No	,S. 13.	Was Deceda If Yas, specif		Hispanic Origin? (S an, Maxican, Puart Specify:	pacify Yas or No- o Rican, atc.)	14. Rac Blac Specifi	ck, Whita,	can Indian, atc. white
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tam oth	ľ	20a. Method of Dis	position		20b. F	Placa of Disp	osition (Nam	a of		Data	20c. Location -	City or To	own, Stata
or H				Removal from Sta	ta Bi	comatary, cra	amatory or off Rose	cei	metery	06/29	Friend	isvil	le MD
artme ortani Injury	-	4 Donation									XO V T T	10.10	
Depar Impor any Ir		21. Signature of Fu	marai sarvica Lica	Scan	011	1.	Cumb	pëi erl	Ti Funerand MD 2	al Home, 1502	P.A.		
	\Box	23a. Part 1. Entar t	ha disaasa, or con	polications that cause on a cause on a ach	ed tha daat	h. Do not ar	ntar tha moda	of dyin	ng, such as cardiac	or raspiratory an	ast,		Approximata
nysiclan		shock or has	rt fallure. List only	ona cause on aach	lina.			-				1	Approximata Intervai Batwaa Onsat and Deat
Medical		Immadiata Causa	Final										
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ng physician and es the buriel-trensit	<u>m</u>	Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Disaase or Injury that Initiated events rasulting in death) Last Dua to (or as a consequence of):											
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tie e	000	Part II. Other signif	Icant conditions	contributing to death	but not ras	ulting in the	undarlying ca	usa div	van in Part I	23b. Did to	nhacen uaa en	ntribute to	o the cause of de
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certificate rector, pag	Be	25. Was casa refer examiner?	red to medical						26. Place of Das	th (Check only or	ne)		
dire	2	1 ☐ Yas 2	No	Hospital: 1 Inpa	itient 2	ER/Outpatie	ent 3 DOA	Oth	ner: 4 Nursing H	oma 5 Rasid	ance 6 □Oth	er (Specif	(v)
er thi		27. Manner of Deat		28a. Date of in (Month, I	njury	28b. Tima	of 28	c. Injui	ry at	28d. Dascribe h	ow injury occur	red	,,
. Aft	읉	Natural 2 ☐ Accidant	5 Panding invastigation		Jay raar)	Injury	M		Yes 2 □ No				
in by th	Certification:	3 Suicide 4 Homicida	6 Could not be datarmined	28a. Place of	Injury - At heatc. (Specil	oma, farm, si	treat, factory,	offica		28f. Location (S City or Tow		per or Rura	al Routa Number,
		29a. Cartifiar	Cartifying Pi	nysician: To tha be	st of my kno	wledga, daal	th occurred at	t tha tir	ma, date and place	, and dua to tha c	ause(s) and ma	annar as s	tated.
Fulletel	edical	(Check only one)	Medical Exa	minar: On the basis	of axamina stated.	tion and/or Ir	nvastigation, i	n my o	opinion, death occu	rred at tha tima, d	lata and place,	and dua to	tha causa(s)
omp omp		29b. Signature and	title of pertitier	11-X	- San	0/	29c.	Licans	sa numbar	2	9d. Data signe	d (Month.	Day, Yaar)
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12		100	aura	W(gue	-0]	D 1	7246		June :	28, 1	.998
1 oc		30. Nama and addr	ass of parson who	complated causa o	daath (Iter	n 23a) (Type	, Print)						
res 1		Dr. Rich	nard Snid	ler, Memon	cial F	lospita	al Sui	te	402, Cumb	erland.	MD 21	502	
State	e	31. Date filad (Mon	Day Yaar)		strar's Signa				,				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Rolland Gale Sipes June 23, 12:26 p.m. 1998 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospital & Medical Center Cumberland Allegany 6. Sex 4□ M 2□ F if Under 1 Year if Under 24 Hrs. 5. Sociei Security Number Date of Birth Wonth, Bay, Year 27 Birthplace (State or Foreign (State or Foreign) 7. Age (In yrs. last birthday) **Funeral** Days 216-22-5527 71 Yrs. Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic avent, the Manical Examiner must be nothed at 10d. Inside City Limits MD Allegany Cumberland Yes 2 No **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 210 Oak Street USA 21502 12. Was Decadent Ever in U.S. Agned Forces? YEI Yes 2 □ No if Yes, Give Year or Dates: Korean Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11 Maritai Status Peges 1 and 2 should be filed within 72 hours after in nent of Health end Mentai Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 Never Married ₹ Married 1 Yes Z No 21215-0020 Specify: þ Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Railroad Carman Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Irvin A. Sipes Clara B. Sullivan ည 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health el Important: If item 27 is any injury or other trau David Sipes-son 12215 McMullen Highway Cumberland MD 21502 20a. Method of Disposition
1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cametery, crematory or other p 20c. Location - City or Town, State Sunset Memorial Park Cumberland MD 06/26 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Servica Licenses Scarpelli funeral Home, P.A. Cumberland MD 21502 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, or heart fellure. List only one cause on each line. Approximete Intervai Between Onset and Death **Physician** /Medical Immediate Cause (Final Myocardial infarction with cardiac arrest disease or condition resulting in deeth) 10 minutes **Examiner** Due to (or es a consequenca of): Physiclan/Medical Examiner The law requires that the death certificate be axecuted detached for use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es e consequenca of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ director, page 2 should be 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? SKI NO 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Piece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1- inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

216-22-5527 Division of Vital Records, P.O. Box 68760,

within 24 hours after deeth.

To the Funeral Director: After this certificata has be or Attending Physician: filled in by Hospital

complataly

State Registrar

Medicai

1 Naturai

2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

ertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

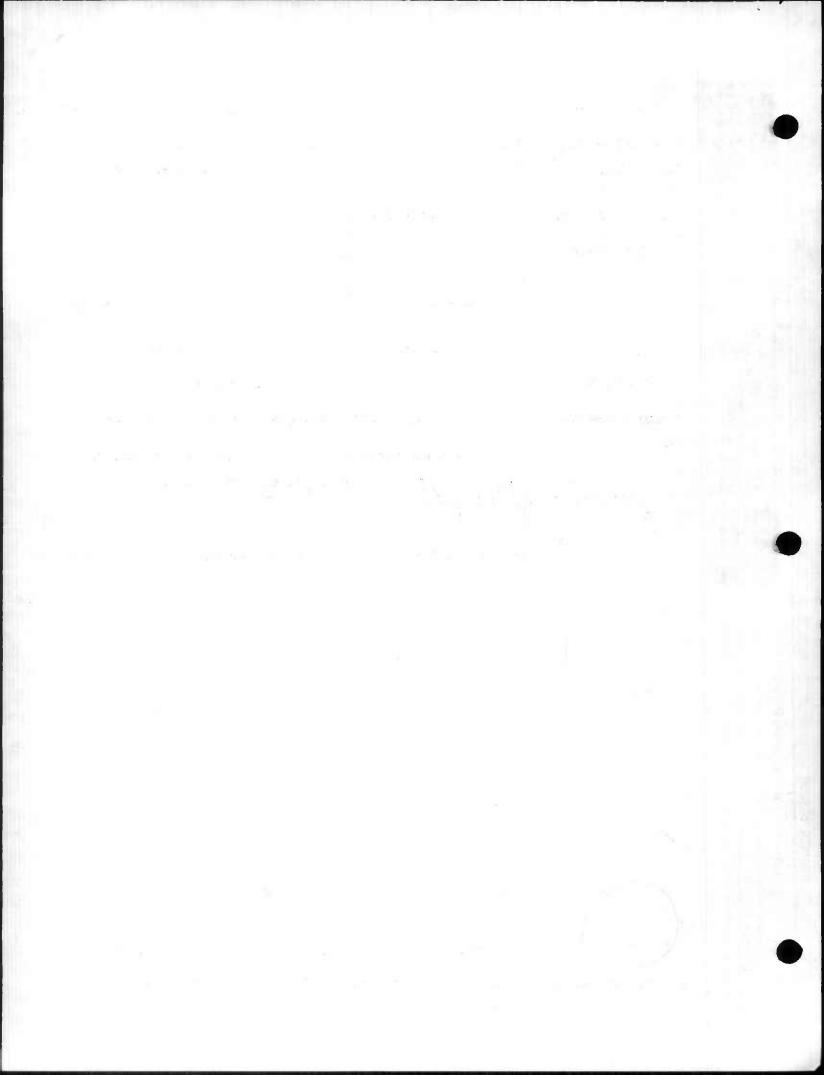
Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29 Signature and title of or 29c. License number 29d. Date signed (Month, Dav. Year) W p D 12779 June 1 1998 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Guy Fiscus, M.D., Memorial Hospital Medical Building, Cumberland, MD

Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)



98-3667-001 CMK SHAWNA SIMPSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene

Department of I	reallir and	Melitai	rrygiene
Certificate of	Death		Reg. No.

	I
Physician	ı
/Medical	
Examiner	ı

Directo

Funeral

þ

Completed

1. Decedent's Nama (First, Middle, Last) SHAWNA DARLENE

218-62-7037 Usual Residence of Decedant

SIMPSON

2. Date of Death JUNE 25,

APRIL 5 1966

4b. City, Town, or Location of Death

3. Tima of Death

1941.PM

MEMORIAL HOSPITAL E.R. 5. Social Security Number

4a Facility Name (If not institution, give street and number)

CUMBERLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Months

ALLEGANY COUNTY Birthpleca (Stata or Foreign Country)

4c. County of Death

Day

1998

Funeral Director

pemit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at 905s.

Physician

/Medical

Examiner

attending physician and for use as the bunal-transit

ed by the a

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paga 2 s

certificate

this funeral

After

within 24 hours after death To the Funeral Director: / completaly filled in by the

director,

the Hospital or Attending Physician:

death.

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/Medical Examine

þ

Completed

Be

2

Certification:

edical

10a. State MARYLAND

11. Marital Status

10b. County ALLEGANY 10c. City, Town or Location CUMBERLAND

Yrs.

10d. Inside City Limits XXYas 2 No

10e. Street and Number

t2. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:

32

21502 Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) U.S.A. 14. Race - American Indian, Black, White, etc.

WHITE

MARYLAND

1 ¬Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorcad

432 GRAND AVENUE

15. Decedent's Education (Specify only highast grade completed)

1 M 20XF

16a. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired)

1 ☐ Yes 2 No Specify:

10f. Zip Code

16b. Kind of Business/Industry

Specify:

10g. Citizan of What Country?

Elementary/Secondery (0-12)

College (1-4or 5+) CHRISTOPHER PHOTO LAB.

PHOTO 18. Mother's Name (First, Middle, Meiden Sumeme)

17. Father's Name (First, Middle, Last)

WILLIAM CHARLES SIMPSON

FAY ARLENE SHROUT

19e. Informant's Name/Relationship (Type, Print)

FAY A. SIMPSON MOTHER 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1964 DURHAM DRIVE CUMBERLAND MARYLAND 21502

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata

20b. Place of Disposition (Name of cemetery, crematory or other piaca)

20c. Location - City or Town, State

4 ☐ Donation 5 ☐ Other (Specify)

SUNSET CEMETERY JUNE 29 1998 22. Name end Address of Facility

CUMBERLAND MARYLAND

MERRITT-ADAMS FUNERAL HOME

23a. Part1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. MARYLAND por compared to shock, or heart failure. List only one cause on each line. Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting In death)

Pulmonary thrombo emboli Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

Dua to (or as a consequence of)

Due to (or as a consequence of)

Part ii.	Othar	significant	conditions	contributing to	death but not	resulting In	the underly	ying cause	given In	Part i

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 26. Place of Death (Check only one)

1 Yes 2 No

25. Was case referred to medical axaminer? 1X Yes 2∏ No 27. Manner of Deeth

1 Natural

2 Accident

3 Suicide 4 - Homicide

28a. Date of Injury (Month, Day Year) 5 Pending invastigation

Hospital:

1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Spacify)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred

29a. Cartifian (Check only one)

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner as stated. 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of cartifian

29c. Licansa number

O.C.M.E.

29d. Date signed (Month, Day, Year) JUNE 26, 1998

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Radentz

82 Fleaturer's Signeture

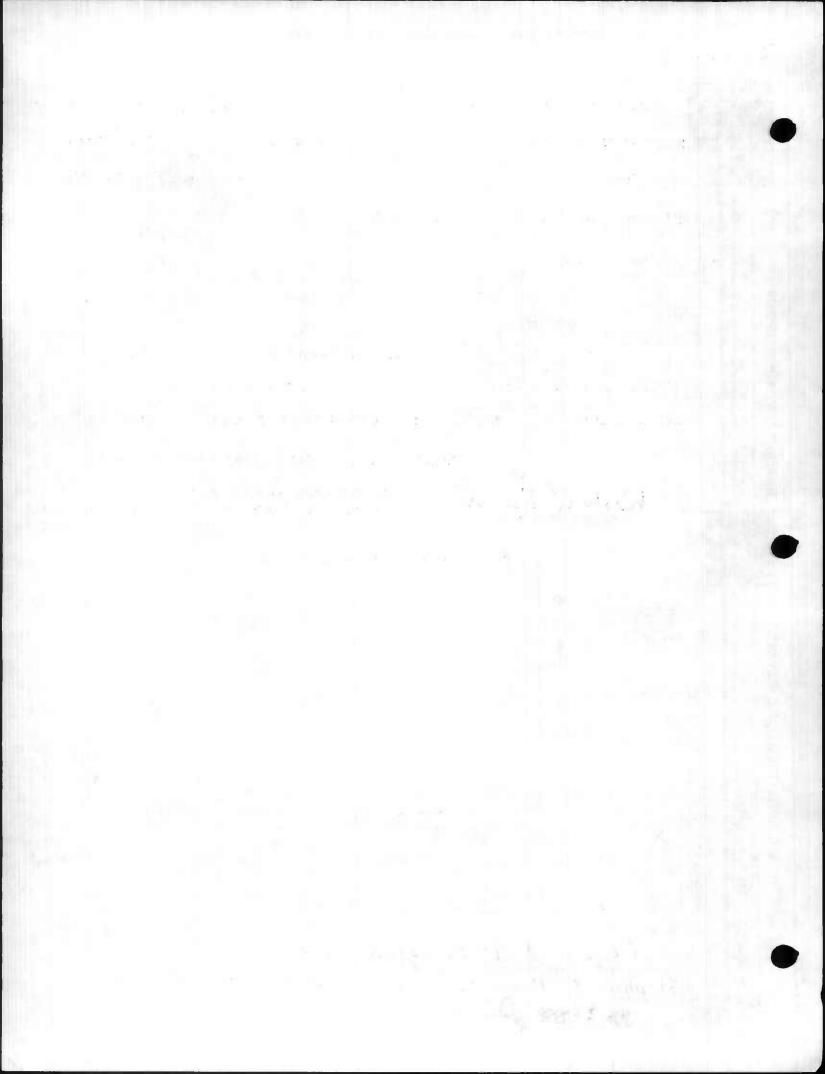
111 Penn Street, Baltimore, Maryland 21201

yes

Registrar

Strohyn S, 31. Date filed (Month, Dey, Year)

2 9 1998



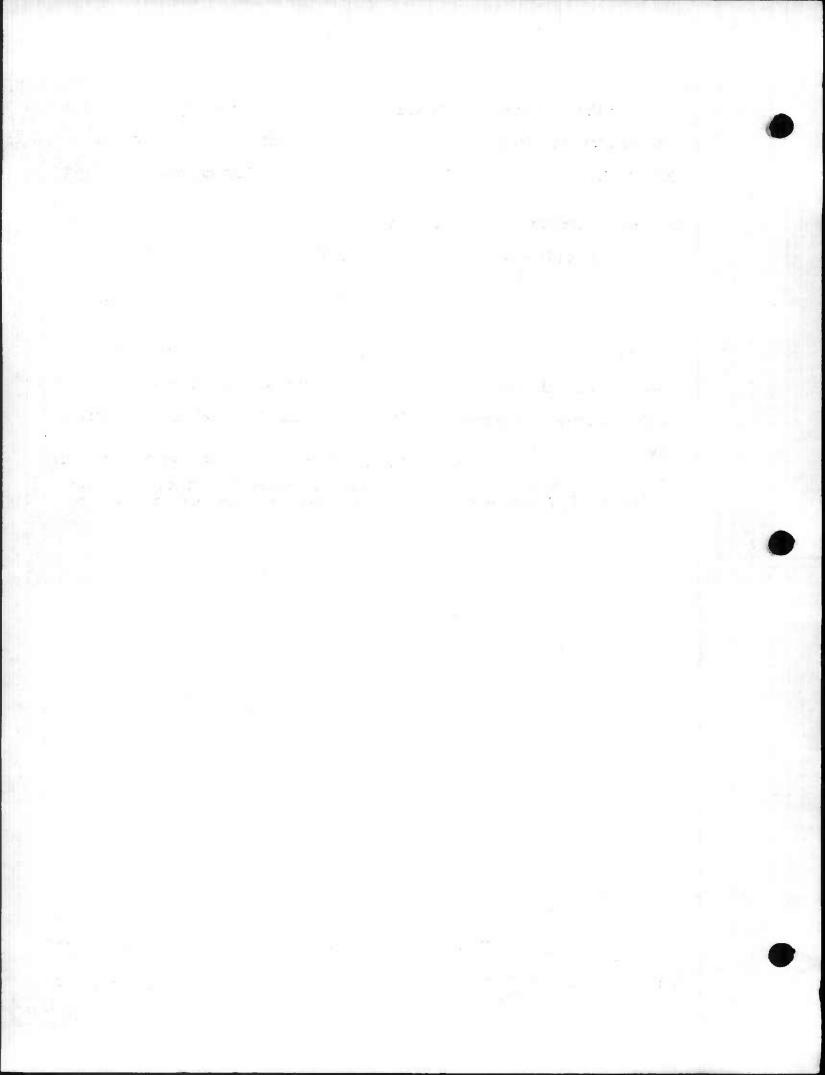
State of Maryland / Department of Health and Mental Hyg

giene	9	8	2	In	10
lea No		_	Berton		1 0

					Ce	rtificate of	Death	R	eg. No.	Lun	1010
			1. Decedent's Name (First, Middle, La	ast)				2. Date of Deel	th	Vace	3. Time of Death
	nysici: Medic	_	Dorothy	Thomson	Thomas			June 21	Day 1998	Year	4:30 PM
	xamin		4e. Facility Name (If not Institution, gir				4b. City, Town, or		4c. County	of Death	-
			203 East MacPhai	1 Road			Bel Air		Hai	rford	
	neral			Sex 7. A 1 □ M 2 🔀 F	ge (In yrs. last birthday) 71 Yrs.	Months Deys			Year) 1927	_ Coun	elace (State or Foreign off) Land
fand	10		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	Od. Inside City Limits
deeth with the Maryland ms 23a or 28a-f show	notfiled at	Director	Maryland Harfo	ord	Bel Air	10f. Zip Code		1	0g. Citizen of V	Vhet Coun	1 □ Yes Ž No
eth with	untbe	rai Di	203 East MacPhai	1		210			USA		
or the	8	by Funerai	11. Meritel Stetus 1 Never Merried	12. Wes Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Dates:	No	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2🔀 No	Hispanic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		k, White,	
6 "		Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occu kind of work done DO NOT use retir	during most of wo	rking	16b. Kind of Bu	isiness/înc	dustry
filed within Hygiene.	t, the M	Comp	Eiementery/Secondary (0-12)	College (1-4or	5+)	nemaker	,		Own Ho		
should be filed within and Mental Hygiene.	ic even	To Be	17. Father's Neme (First, Middle, Last James (nmn)	homson			18. Mother's Nar Sophie	me (First, Middle, I Tess St	Ma <i>ide</i> n Sumam tiersto:		
od 2 inh ar	r trauma		19a. Informant's Name/Ralationship (Stanley M. Thomas				et and Number or Re acPhail R				
vermit. Peges t ar Department of Hear mportent: If Nem.	ry or othe		20a. Method of Disposition ↑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			matory or other pl	Gardens		20c. Location - Bel Ai		
permit. Departm	any Inju		Someture of Funeral Service Log			Neme end Add Howard	ress of Facility K. McComa	s III Fw	neral H	ome,	P.A.
-		\dashv	23a. Part I. Enter the chiese, or conshock, or hee stature. List only	inlications that cause	d the deeth. Do not en					Mary	yland 2101 Approximate
certificate be executed with a special control of the control of the certificate and certificate and certificate and certificate and certificate certi	es the burial-transit	n/Medical Examiner	disease or condition resulting in death) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Non-in	Dua to (or as a consecutive to (or a)	quence of);	Diab	letes,	nelli	tus	
e death certifi	detached for use	Physician	Part II. Other significant conditions of	contributing to death t	out not resulting in the u	nderlying cause g	iven in Pert I.	23b. Did to	bacco use cor	tributs to	the causs of death?
hat the	ac.	by Phy						1 🗆 Y	08 20 No	3 Prot	bably 4 Unknow
ew requir	2 should	Completed b						24a. Was a perform	n autopsy med?	evi	ere autopsy findings aileble prior to mpietion of cause death?
F #	director, page	9	/					1 🗆 Ye	es 2010	10	Yes 25 No
ilctan: The	ector.	Be	25. Was case referred to medical examiner?					ath (Check only on	(9)		
문 등	<u>6</u>	on: To	1 Yes 2 10 27. Mannar of Death 1 Desturai 5 Pending	Hospital: 1 Inpati 28a. Data of Inju (Month, Da		28c. Inj	ury at ork?	forma 5 Aeside 28d. Dascribe ho			y)
To the Hospital or Attending in Within 24 hours after death. To the Funeral Director: After	in by the f	Certification:	2 Accident 3 Sulcida 4 Homicide	e 28e. Place of In	jury - At homa, farm, str c. (Specify)		Yes 2 No	28f. Location (St City or Town	treet and Numb n, State)	er or Rura	il Route Number,
To the Hospital within 24 hours To the Funeral	completaly filled in by	edicai C	29a. Certifier (Check only one)	nysician: To the best niner: On the basis of end manner st	of my knowledga, death f examination and/or In- ated	n occurred at the t vestigation, in my	ima, data and piace opinion, death occu	and due to the curred at the time, d	ause(s) and ma ata and place, a	nner as st	ated. the cause(s)
o the	dwo	M	29b. Signeture end title of certifier	Jilo mariner of		29c. Licer	ise number	2	9d. Dete signed	i (Month.	Day, Year)
HSF	6		mygret	es, M	$\cdot \mathcal{D}_{\cdot}$						
10			30. Name and addless of person who	PETERS	death (Item 23a) (Type, $\mathcal{H}\cdot\mathcal{D}$. –	Print) 104 PU	IMTREE	R.D. BE	TL ALR	M	1998 p 2/014
Re	Stat egistra		31. Date filed (Month, Day, Year) 8	PART POR	ets sign Rusdall			1			

DHMH 16 Rsv 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth Month Dev Yaar NELLTE TWIGG Τ. 25, 1998 8:30 A.M. June 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth The Memorial Hospital and Medical Center Cumberland Allegany 7. Age (In yrs. last birthdey) If Under 1 Year Months Days If Undar 24 Hrs. Hours Min. Dete of Birth Month, Day, Year) 1913 5. Social Security Number Birthplece (State or Foreign Country) 50X 1□M 2□F 216-38-1520 Usuel Rasidenca of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Cumberland 1X Yes 2 No Allegany 10e. Straet end Number 10f. Zip Code 10g. Citizan of Whet Country? 718 Elm Street USA 21502 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3X Widowed 4 ☐ Divorcad white 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Charles Turner Katherine (Smith) 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) James Twigg--son 87 Mary Street Bordentown NJ 08505 20b. Plece of Disposition (Neme of cametery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlal 2 ☐ Cremetion 3 ☐ Removel from State Oliver Grove Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 06/28 Oldtown MD 21. Signature of Funeral Servica License 22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23e. Pert1. Enter the disease, or complications that caused the leeth. Do not enter the mode of dylng, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Betw Onsat and Death Immediete Ceuse (Final disaasa or condition resulting in deeth) Coronary Artery Disease 8 Years Due to (or es s consequance of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseasa or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piece of Deeth (Check only one)

Physician /Medical Examiner

permit. Pege Department of Important: If any Injury or

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

"natural", or items 23e or 28a-f show

Peges 1 and 2 should be filed within 72 hours efter death a neat of Health end Mental Hygiene.
Int: If flear 27 Is marked other than "natural", or flems 23.
Int or other treumatic event, it a Neate Ear in the man

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

Director

Funeral

Completed by

Be

the Marylend

With

the buriel-trensit 98 esn ate has been signed by the etter page 2 should be deteched for certificate director, this Iuneral After

Physician/Medical Be

The law requires that the death certificate be executed or Attending Physician: efter death. the yd ni bellii a Funeral Hospital within 2 To the To the

State Registrar

Examiner þ Completed Certification: To

Medical

29b. Signature end title of certifie

5 Pending

invastigation

6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

29c. License number

D 36766

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Other: 4 ☐ Nursing Homa 5 ☐ Residenca 6 ☐ Other (Specify)

112 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

Ju

29d. Dete signed (Month, Dey, Year)

11,1998

28d. Describe how Injury occurred

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Vik Poonai, M.D.,922 National Hwy, LaVale, Md. 21502

31. Dete filed (Month, Dey, Year)

1 Yes 2 No

27. Menner of Deeth

1 Neturel

2 Accident

3 Sulcide

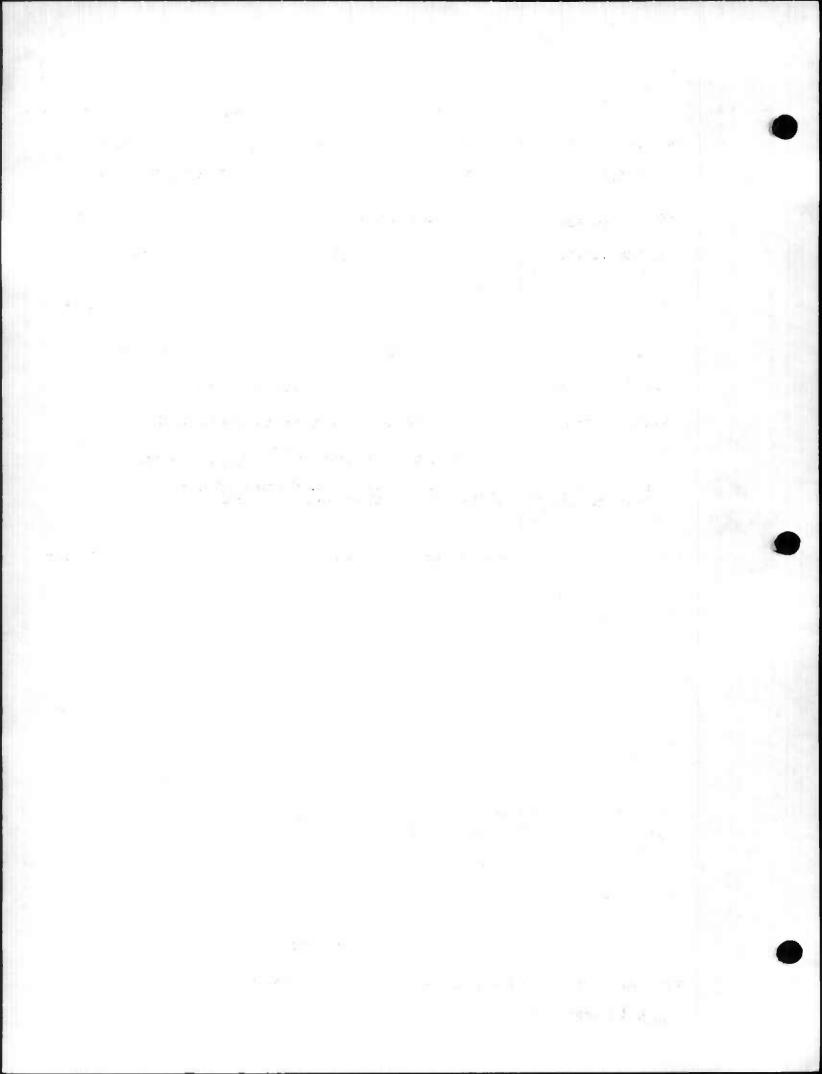
29a. Certifier

4 | Homicide

(Check only one)

2 6 1998





Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month -Year 98 **Physician** Williamson Glenn 26 Dalton 7:36 AM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Bethesda Montgomery Bethesda Suburban Hospital If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Min. 520-32-3127 1 M 2 □ F Days Hours 65 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits of Health and Mantal Hygiene. Items 23a or 28a-f above other 27 is marked other than "natural", or items 23a or 28a-f above other treumstic avant, the Medical Experies Frust be notified at VA Herndon Fairfax 1 XYes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nit. Pages 1 and 2 should be filed within 72 hours after death with I sertment of Health and Mertal Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or injury or other transmant. The Mexical Engine USA 20170 1510 Sadlers Wells Dr. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 (2X) Yes 2 □ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married White 1 XYes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Computer Software Human Resources 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Henry Ray Williamson Vara S. White 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 1510 Sadlers Wells Dr., Herndon, VA 20170 Sandra J. Williamson altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3X Removat from State Department of Important: If Imperial Mem. Gardens 7/3/98 Pueblo, CO 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Iny Herndon, Green Funeral Home, 721 Elden St., VA ns that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Intervat Between Onset and Death Enter the disease, or com, or heart failure. List only **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medicai ary thmia Ventricular audiac' Examiner Due to (or es e consequence of): Physician/Medical Examiner artem Disease orman Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last (or es a consequence of): Division of Vital Records, P.O. Box 68760 meente hea Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of deeth? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ 2 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed has **page** 2 1 ☐ Yes 2 ☐ XNo 1 ☐ Yes 2 ☐ No certificate Be 25. Was cese referred to medicat examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ₹ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth funeral 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Alter or Attending 5 Pending 1 Yes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide A 24 her. 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) end manner es stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated. To the Within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

0101048232

Sunset Hills Road Reston VA 20190

State Registrar myou mo

DR. LO-An

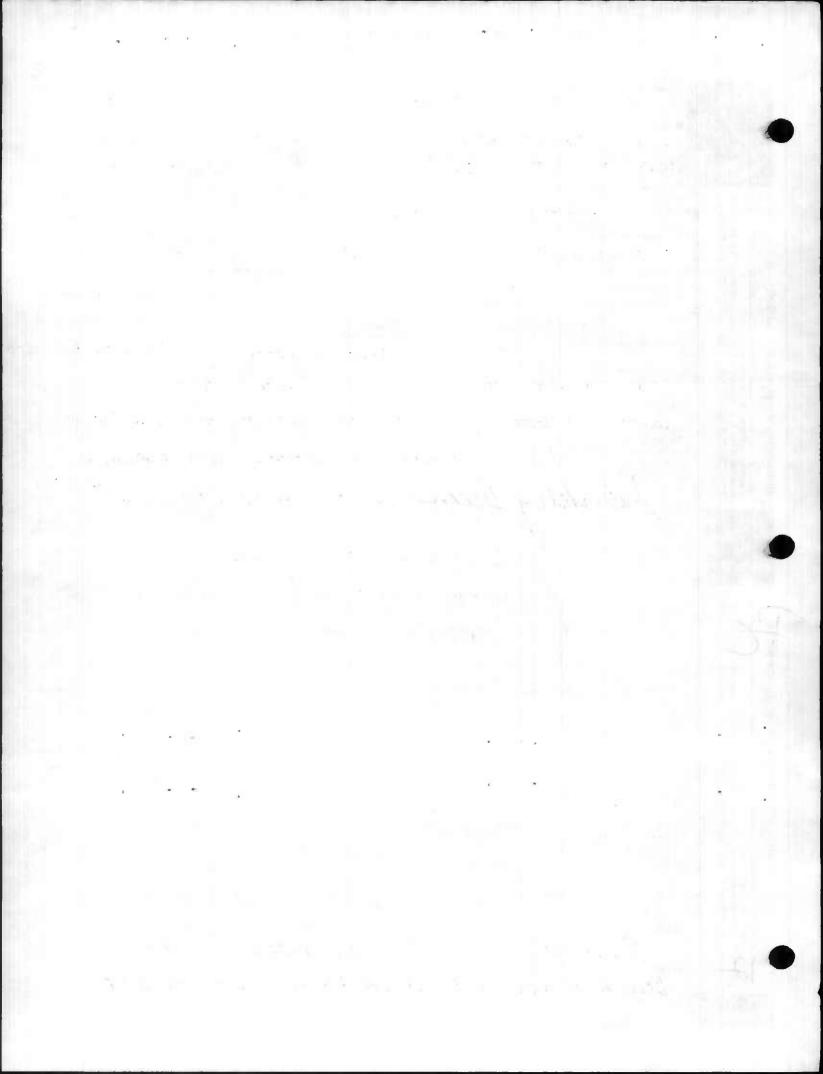
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

Nagyen

11445

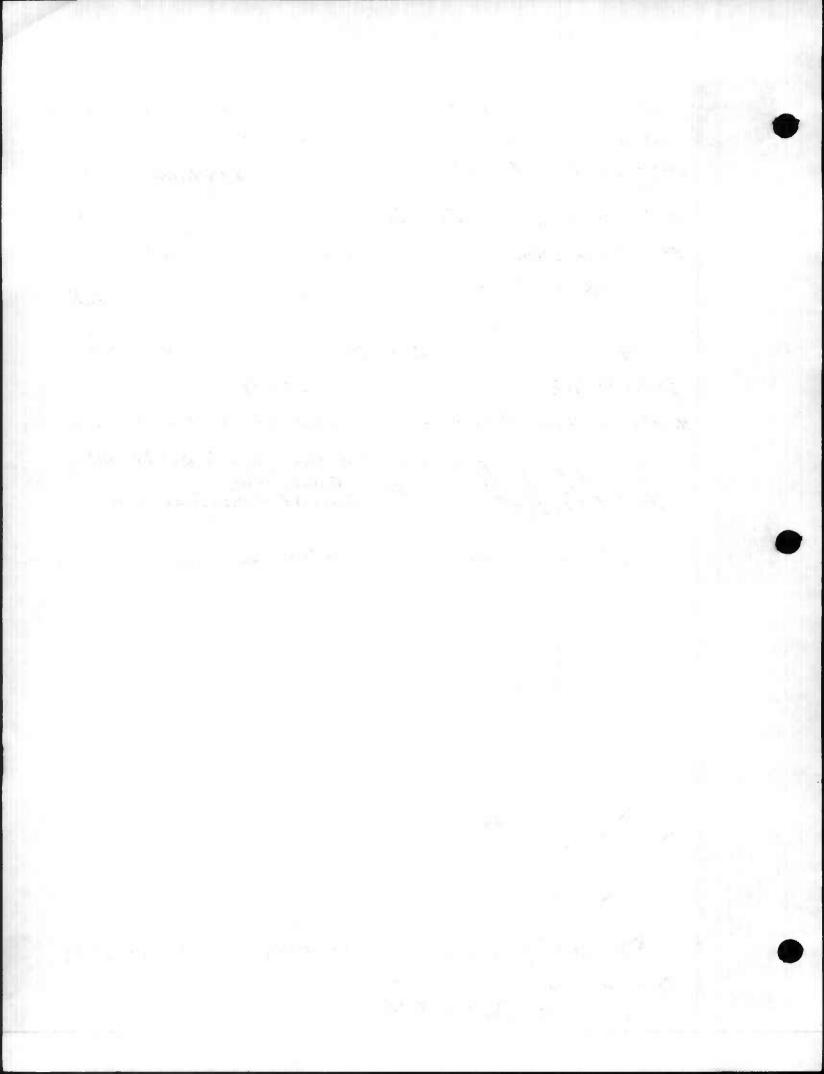
32. Registrar's Signature

-widson-Randell



State of Maryland / Department of Health and Mental Hygiene Q 2 1 0 1

						Certificate of	f Death		Reg. No.) (1013		
П	-		1. Decedant's Nama (First, Middla, Las	it)				2. Data of Das	ith		3. Tima of Deeth		
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Ŋ.	Examir		As Facility at a second of the				4b. City, Town, or				10.00 141		
			Mariner Health o	f Forest H	Hill		Forest	Hill	Harf	ord			
	Funeral Director		5. Social Sacurity Number 6. Se		a (In yrs. last b	irthday) If Under 1 Yea Months Days	r If Undar 24 Hrs	8. Data of Birt		_	placa (Stata or Foreign		
	P		Usual Rasidance of Dacadant						111/2				
	show		10a. Stata 10b. County			wn or Location					10d. Insida City Limits		
	e Ma	cto	MD HARFOR	0	Beli	HIR					1 ATYas 2 No		
	in 72 hours after death with the Maryland "natural", or items 23a or 28a-f show paired Examine result to notified at	Funeral Director	10e. Street and Number 503 Kemmore.	Ave		10f. Zip Coda 2/0/4	4		10g. Cifizen of V	What Coul	ntry?		
	items items	inel	11. Maritel Status	12. Was Dacedent E Armed Forces?	ever in U,S.	13. Was Decedant of If Yas, specify Cu	Hispanic Origin? (S	specify Yas or No-	14. Rac	e - Amaric	can Indian,		
21215-0020	ours after	by	1 ☐ Never Married 2 Married 3 ☐ Widowad 4 ☐ Divorced	1 ☐ Yas 2 A N If Yas, Give Year or Datas:	lo	1□Yas 2MN		o moun, ato.,	Specify	171	ACK		
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Maryland	S E S	To Be	DEAN Miller				Chari	ma, (First, Middla,	Maidan Suman	78.)			
Jar	2 0 0 5		19a. Informant's Neme/Ralationship (7	./ /	/	b. Mailing Address (Street		1 - 1	r, City or Town,	Stata, Zip	Code)		
	日日のト		Harold WATTER	25 - Husb	•		MORE 57		Lie W		2014		
lore			20a. Mathod of Disposition 1 Disposition 3 Disposition	Ramoval from Stata	20b. Plece cemet	of Disposition (Name of ary, crematory or other pl	aca)	Data	20c. Location -	City or To	own, State		
‡	tmen tant: jury		4 □ Donation 5 □ Other (Specify	1	Bell	ir Men	COAN	6-20-98	BelAi	R M	0		
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funarel Sapuce Ideans	0		22. Nama and Add	ress of Eacility 4	give,		1117	•		
			23a. Part1. Entar tha disaase, or comp	lications that caused	tha daath. Do	not entar tha moda of dy	Ing, such es cardia	c or raspiratory an	rest,	101	Approximata		
	Physician		23a. Part 1. Entar tha disaase, or complications that caused tha daath. Do not entar tha mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approx Interval Onset										
	/Medical	П	Immedieta Causa (Final disaasa or condition	h.	7	11	lon c				Ci		
	Examiner		rasulting in death)	a. ///	Dua to (or es a	consequence of):	- 4021 5	eur	_	-	CT year		
_	D #	ner			(41)	,							
	the death certificate be executed by the attending physician and ached for use as the bunal-transit	Examiner	Sequentially list conditions,	b	Dua to (or as a	consaquence of):							
60,	be ex ician buna		Sequantially list conditions, if any, laading to Immediata causa. Enter Underlying Causa (Disaasa or Injury	C									
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P.0	the ache	hys	Tattit. Other significant conditions co	intributing to death ou	it not resulting	in the underlying cause g	wen in Part I.				bably 4 Unknown		
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of Vital Records,	quira: on sig uid b							24a. Was	an autopsy	24b. W	ere autopsy findings		
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>	Physician: rthis certific rral director,	To B	axaminer?	Hospital: 1 ☐ Inpatiar	nt 2 ER/O	utpatient 3 DOA	than 1	fome 5 ☐ Rasid		er /Specil	64)		
0	a Physer this seral		27. Mennar of Deeth	28a. Data of Injury (Month, Day		Tima of 28c. Inju		28d. Dascribe h			,,		
Division	Attanding In death.	Certification:	Naturel 5 Panding 2 Accidant invastigation	(Month, Day	rear)		ork? ☐Yas 2☐No						
Vis	Atte	tific	3 Sulcida 6 Could not be datarminad	28a. Place of Inju	ry - At home, f	arm, straat, factory, office	1	28f. Location (S City or Tow	traat and Numb	er or Rura	al Routa Number,		
Ö	rs after or all Direction	Ce		odinariy, ato.	. (Opecity)			Oily or You	n, Olalay				
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral	edical	29a. Certifiar (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the bast of iner: On the basis of and mannar stat	exeminetion at	e, death occurred at that nd/or Investigetion, in my	time, date end plece opinion, daath occu	e, and dua to tha corred at tha tima, c	ausa(s) and ma data and place,	innar as s end due te	tatad. o tha causa(s)		
	To the To the Somp	Me	29b. Signatura and title of cartifiar			29c. Licar	nsa numbar	1	29d. Date signe	d (Month,	Day, Yaar)		
			Day OX			0	32279		1.	12	KSJ		
			30. Name end eddrass of parson who c	ompleted cause of de	eth (Item 23e)		3-617		June	17)	17)		
	u		Dav. D 5 3	(Lun (15 4	J. MA- Ph	9./						
	Sta	te	31. Dete filad (Month, Day, Year)	32 Registra	r's Signatura	2.1.11				1			
	Registr	ar	JUN 1 8 199	8 grando	Sherry W	antelli				- 1			



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month Day 1998 June 25, George Alfred Walbert 9:31 a.m. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Magnolia Hall Nursing Home Chestertown Kent 5. Social Sacurity Number 6. Sax 1 X M 2 □ F If Undar 1 Year if Undar 24 Hrs. Hours Min. 8. Deta of Birth (Month, Day, Yeer) 9. Birthplaca (Stata or Foraign Country)
December 23, 1917 Rock Hall, Maryland 7. Aga (In yrs. last birthday) **Funeral** Months Days 220-05-0746 80 Yrs Director Usual Rasidanca of Decedant Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene. nt: if item 27 is marked other than "natural", or items 23s or 28s-f show 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Moderal Examiner mant be not fed at 1 XYas 2 No Directo Maryland Kent Chestertown 10e. Street and Number 10f Zin Code 10g. Citizan of What Country? 200 Morgnec Road 21620 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 M Yas 2□ No. If Yas, Giva Yeer or Datas: 11. Maritai Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, 1 Naver Marriad 2 Marriad Maryland 21215-0020 1 Yas 2 No White by Specify: 3 Widowed 4 □ Divorcad Completed 15. Decedant's Education (Spacify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Eiementary/Secondary (0-12) Collega (1-4or 5+) Seafood Waterman 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Surnama) James A. Walbert Clara Rebecca Biggs 19a. informant's Nama/Relationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Depertment of Health ar important: If Item 27 is any injury or other trau Rebecca Meikle PO Box 78, Worton, Maryland 21678 Baltimore, 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 20b. Placa of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Other (Specify) June 28, 1998 Worton, Maryland Christ I.U. Cemetery 21. Signature of Funaral Sarvica Licensaa 22. Nama and Addrass of Fecility Fellows, Helfenbein, & Newnam Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat end Deeth **Physician** 3dop Rosp failure /Medical Immediete Causa (Final diseasa or condition rasulting in daeth) Due to (or as a consequence of) Examiner hemmonia To the Hospital or Attending Physician: The law requires thet the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaesa or Injury that intieted avants rasulting In daath) Last Dua to (or as a consequence of) pue End Stage Atzpheiners Division of Vital Records, P.O. Box 68760. ettending physician Physician/Medical ate hes been signed by the e page 2 should be deteched t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Hx Compressionfx 76 Tz; @ Hipfx; Hx huntiple 1 Yes 2 No 3 Probably Munknown Be Completed by 24b. Wara autopsy findings evailable prior to completion of cause of deeth? Episodes Pueunonia; S/PTURP; Herectal Polyp 24e. Wes an eutopsy performed? Hx Aluery & certificate 1 Yas 2 No 1 Yas 2 No 25. Wes cesa rafarred to medical axaminar? 26. Place of Deeth (Check only ona) Other: 40 Nursing Homa 5 Rasidanca 6 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this in by the funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death Medicai Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1. Natural death. 1 ☐ Yas 2 ☐ No 2 Accident efter death 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicide within 24 hours of To the Funeral Di completely filled in Certifying Physician: To tha best of my knowledge, deeth occurred at tha time, date end place, and dua to tha causa(s) end mennar as statad.

2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) end mannar stated. 29a, Cartifiar 29b. Signatura and title of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) D50996 6/26/98 5 30. Neme and addrass of person who completed causa of death (itam 23a) (Type, Print) 100 Brown St Chestortown MD 21620 Deil Staddard MD 31. Dete filed (Month, Dey, Year) JUN 26 32. Registrar's Signetura State Julie Veridson Pendere Registrar

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Deal 4b. City Town, or Location of Deeth 4a Facility Neme (If not institution, give street and nymber, Examiner 62 Sa te or 8. Date of Birth (Month, Day, If Under 1 Yeer If Under 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 216-86-962 Months Hours Min 1 ☐ M 2 🕱 F Yrs. Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f ahow any Injury or other traumatic event, the Mental Exactions must be numbed. 10b. County 10a. Stete 10c. City. Town or Location 10d. Inside City Limits Maryland 1 Nes 2 No Directo more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 8 21 60 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece -American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 28 No Specify: p AFFICAN 3 ☐ Widowed 4 ☐ Divorced Hmerican Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
fie. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) oun 0 any 18. Mother's Name (First, Middle, Melden Sumarne)
Mary Boston 17. Father's Name (First, Middle, Last) Be 050 nox Knox 19a. Informant's Name/Relationship (Type Print) (Quit 19b. Mailing Address (Street end Number or Aural Route Number, City or Town, State. Zip Code) 1240 poston alto, 20b. Placa of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremetion 3 F 4 Donation 5 Other (Specify) 3 Removal from State Mem. Garden 22 Name and Address of Fecilin 21. Signature of Funeral Service Licensee SS Joseph a ations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, a cause on each line. Balto, Md. 21216 Enter the disease, or complice, or heart failure. List only one Approximate Interval Between Onset end Death **Physician** MATASTATIC BREAST CENCEN Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Due to (or as a consequence of) by Physician/Medical Examiner attending physician end for use as the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of): ed by the a 23b. Did tobacco use contributa to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Completed peeu has 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 24 hours efter death.

Funeral Director: After this certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 70 Hospital: Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 5 N Residenca 6 □Other (Specify) 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. tnjury at Work? Certification: 5 Pending Investigation or Attending 1 Netural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1🗹 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) end menner es stated. 29a. Certifier Medical pletely (Check only one) 2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and placa, end due to the cause(s) To the within 2 To the and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1183 20 30. Name and address of person no completed cause of death (Item 23a) (Type, Print)

Johns Hopkins ONLOLO,

37. Registrer's Signature

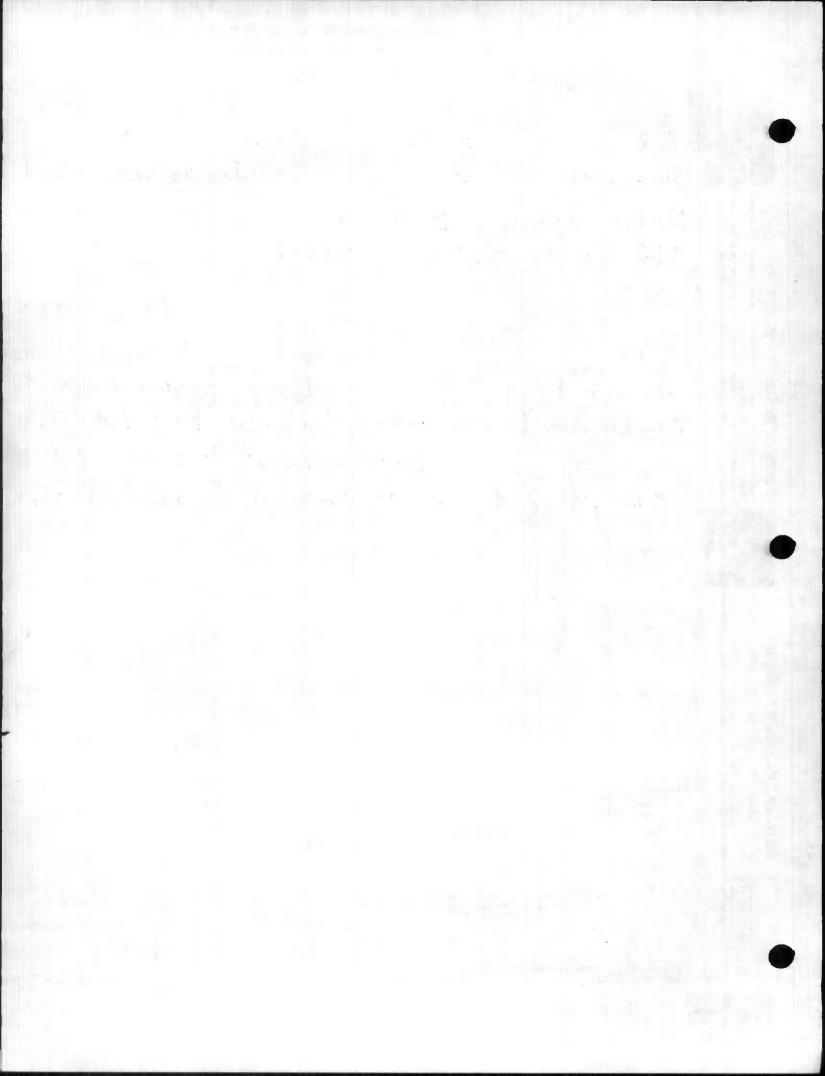
a Davidson

CESTER

Baltimone MS 21287

State Registrar JOHN TEHIO

MD



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death

	1. Decedent's Neme (First, Mid	idie, Last)
Physician /Medical	MICHAEL	BRO
Examiner	4a Facility Neme (If not institute	ion, give s

Directo

Funeral

by

Completed

MICHAEL BROOKS

2. Dete of Death Month JULY

3. Time of Death 04, 1998 5:29 PM.

4a Facility Neme (If not institution, give street end number) 3700 FERNHILL AVE.

2660

N/A

4b. City, Town, or Location of Deeth

BALTIMORE

4c. County of Deeth

Funeral Director

Item 27 is marked other than "natural", or Items 23s or 28s4 show other trsumstic event, the Medical Examinar must be notified at

2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or har

Jemit. Pages 1 and 2 shc.
Department of Health and M.
Important: If Item 27 is many Injury or other.

Physician

/Medical

Examiner

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signed by the a d be detached f

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Hospital To the Hospital within 24 hours e To the Funeral E

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Examiner

Physician/Medical

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Completed

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Certification:

Medicai

Maryland 21215-0020

altimore,

Division of Vital Records, P.O. Box 68760,

the Marylend

with 1

death

92 218 Usuel Residence of Decedent 10e. Stete 10b. County

5. Sociel Security Number

10c. City, Town or Location

Yrs.

7. Age (In yrs. last birthday)

19

If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Date of Birth (Month, Day, Year) MAR. 8, 1979 MARYLAND

10e. Street and Number

BALTIMORE 10f. Zip Code 10d. Inside City Limits 1 Yes 2 □ No

9. Birthplece (State or Foreign

AVENUE

1 M 2□ F

21215

10g. Citizen of What Country? U.S. OF A.

MD.

1 Never Merried 2 Married 3 ☐ Widowed 4 ☐ Divorced

3723 DOLFIELD

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No It Yas, Give Yeer or Detes:

 Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

14. Race - American Indien Bleck, White, atc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)
N/A

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Businass/Industry

Elementery/Secondery (0-12) N/A

UNEMPLOYED

17. Fether's Neme (First, Middle, Last)

MICHAEL DENNIS BROOKS, SR.

18. Mothar's Neme (First, Middle, Meiden Sumeme)

PAMELA GRAY

19e. Informent's Neme/Reletionship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3723 DOLFIELD AVE, BALTO., MD. 21215

(MOTHER) PAMELA GRAY 20e. Method of Disposition

20b. Plece of Disposition (Name of cemetery, crematory or other plece) MT. ZION CEMETERT 7/11/98 20c. Location - City or Town, Stata BALTIMORE, MD.

4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Furnish Service License EWTS T.

1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State

22. Name and Address of Facility
LEWIS T. GWYNN FUNERAL HOME

21215-6393

23a. Pent1. Enter the disease, or complications that in itself the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on such line.

4517 PARK HEIGHTS AVE. BALTO., MD. Approximate fntervel Between Onset and Death

26. Place of Deeth (Check only one)

Immedieta Ceuse (Finel diseese or condition resulting in death)

MULTIPLE GULBHOT

Due to (or as e consequenca of)

GWYNN

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting In deeth) Lest

Due to (or es e consequence of)

Due to (or es e consequenca of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 Yss 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wera autopsy findings eveileble prior to

1 DYes 2 No completion of cause of death? 1 Yes 2 No

25. Wes case referred to medical examiner? 1 Yes 2 No

5 Pending

Investigation

27. Menner of Deeth

2 Accident

1 Neturel

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 4 98

28b. Time of 17201

Other: 4 Nursing Home 5 Residence (Specify) 28c. Injury at Work? 1 Yes 2 40

28d. Describe how injury occurred SM3 JECT WDS

SCENE SHOT.

6 ☐ Could not be detarmined 3 ☐ Sulcide 4 M Homicide 28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) CAR-POADWAT

281. Location (Street and Number or Rural Route Number, City or Town, Stete), 3700 FERNHILL DUE BAUTHORE HUM

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the causa(s) and mannar as stated.

2 XMedical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end mannar stated. 29e. Certifier (Check only one)

29b. Signature end title of cartifier

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) JULY 05, 1998

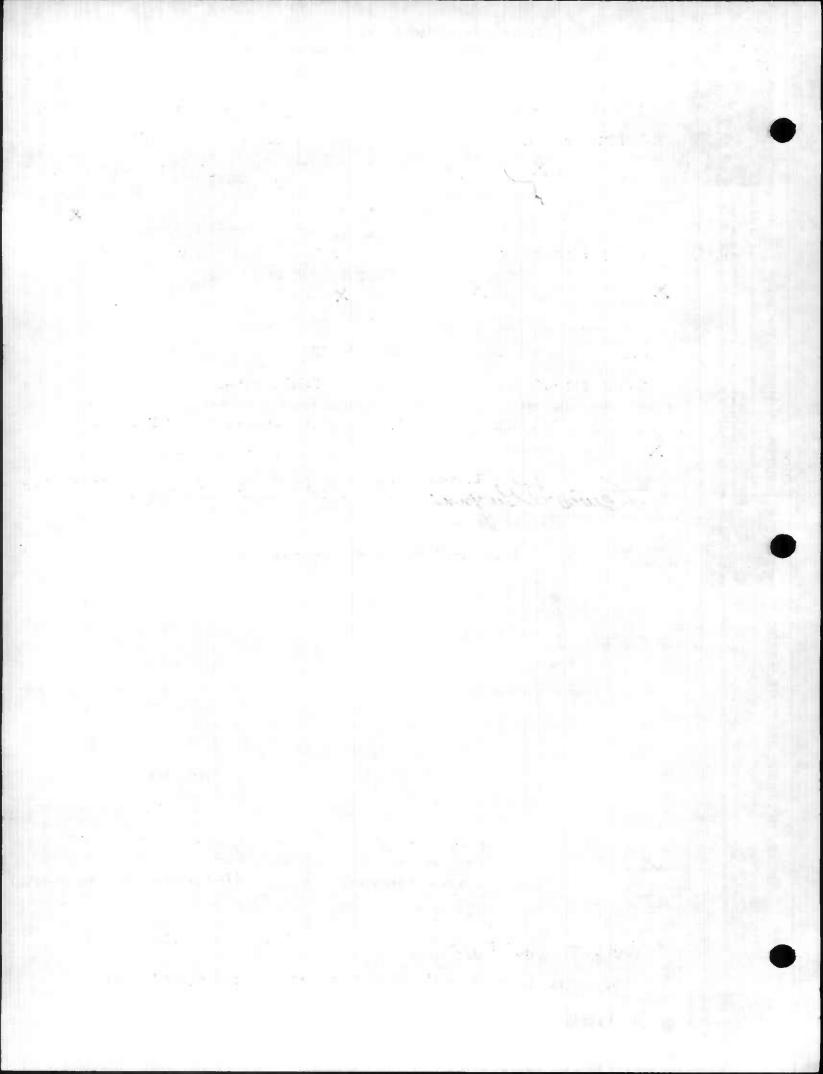
allynte 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

. L ONGL 111 Penn Street, Baltimore, Maryland 21201 MARYDAITS 31. Dete filed (Month, Dey, Year)

Registrar

JUL 091998

32. Ragistrer's Signeture Julie Tairdson Rondose



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decadent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** Josephine 3:52 pm 1998 ances /Medical 4b. City, Town, or Location of Deat 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner iquare dale saltimore ortal 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,) If Undar 24 Hrs 5. Social Sacurity Number 9. Birthplece (State or Foreign **Funeral** Days 1 M 2 F Months Hours 212-36-2972 60 1938 Mary Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23s or 28s-f show traumatic event, the Magical Examiner must be notified at 1 K Yas 2 □ No Director Delaware 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? filed within 72 hours after death with Hygiena. United States of America 19939 rive Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ₹ No If Yes, Give Yeer or Detas: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Black, White, etc. 1 Never Merried 25K Married 1 Yes 2 No Specify P 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedant's Education (Specify only highast grada completed) Elemantery/Secondary (0-12) Collaga (1-4or 5+) E.A. Engineering ctions 10 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be Pages 1 and 2 should be 1 nent of Haaith and Mental Andrew KOZIOWSKI aura SZEWCZYK 19b. Meiling Addrass (Streat and Number or Rural Route Number, City or Town, State, Zip Code) department of Hastim an important: if item 27 is m any Injury or other once. 19e. Informant's Name/Reletionship (Type, Print) Robert B. Blake Daasbord 20b. Place of Disposition (Nama of cemetery, crematory or other place). Husband Delaware 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cramation 3 □ Ramoval from Stata July Baltimore, Baltimore Nationa 4 ☐ Donetion 5 ☐ Other (Specify) Maryland 21. Signatura of Puneral Service Licensee 22. Name and Addrass of Facility Dabrowski-Chojnacki F.H.'s F S Dundalk Ave. Baltimore, MD 21224 100 23a. Part. Effer the disease, or complications that caused the deeth. Do not enter the mode of dying, euch es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on aight line. Approximate Intervel Batween Onset and Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in daath) Examiner Physician/Medical Examiner -ip(1 ntricular Sequentielly list conditions, if any, leading to immediate causa. Enter Underlying Causa (Diseasa or injury that initiated events resulting in deeth) Lest Alten Dronary Dua to (or as a consaquance of) The law requires that the death certificate signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to should I Completed 24a. Wes an eutopsy performed? completion of ceuse of death? s cartificate hes b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 124 hours after death. Funeral Director: After this carifica director. 25. Was casa referred to medical Be 26. Placa of Death (Check only ona) Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accident rector: / 3 Suicida 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Al within 24 hours after To the Funeral Direc completely filled in b 4 I Homicide Medical 29a Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner as steted. 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceusa(s) end manner steted.

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68750

State

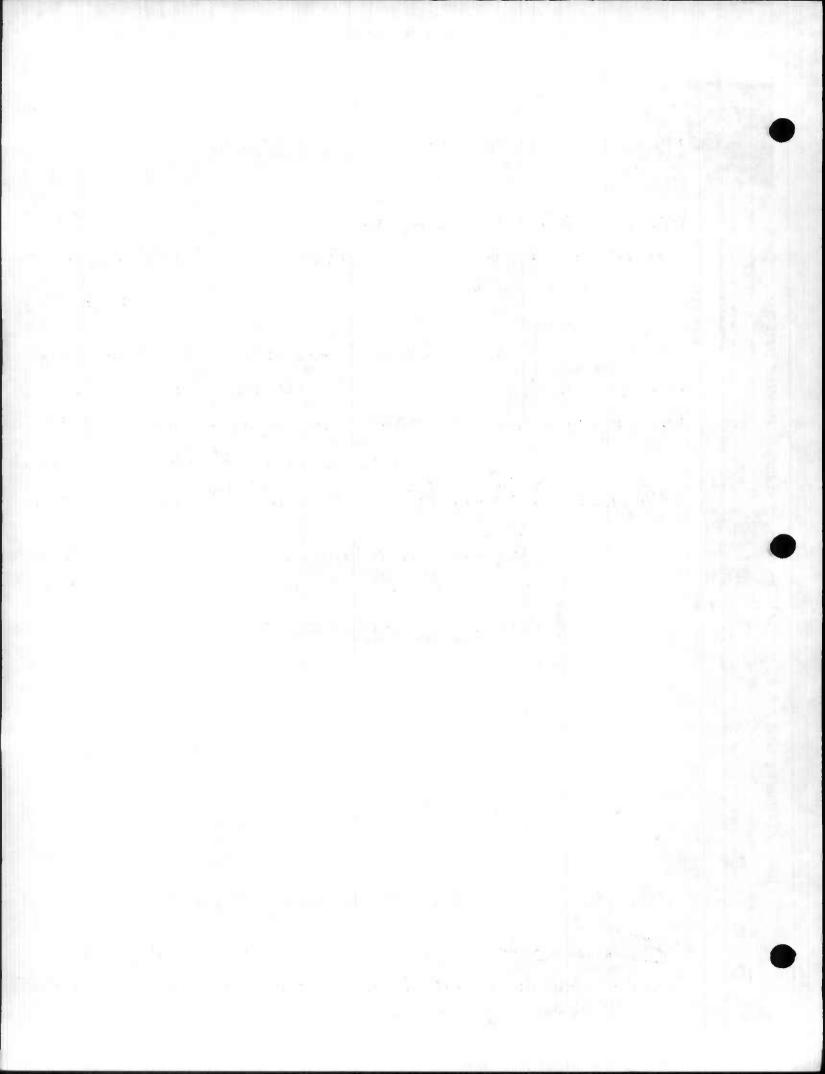
29b. Signature and title of certifier

Nama and address of person who complated causa of death (Item 23a) (Type, Print)

29c. License number

29d. Data signed (Month, Day, Year)

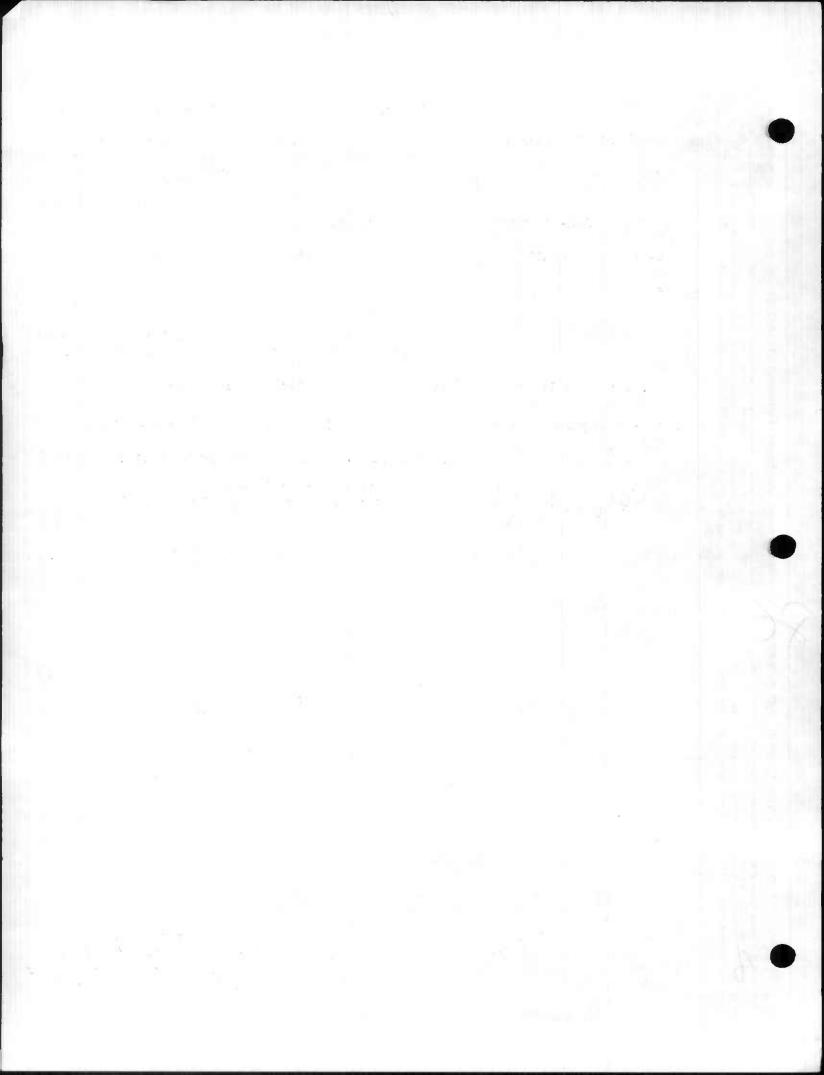
Baltimore, MD 21237



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8

			Cen	tificate of	Death	Reg	. No.	210	10	
Physician	1. Decedent's Name (First, Middle, Las					2. Date of Deeth Month	Day	Yeer 3. T	ima of Death	
/Medical	George	W.	Bradle	у		July 8,	1998		:24 AM	
Examiner	4e Facility Neme (If not institution, give				4b. City, Town, or L		4c. County			
	8135 Tower Brid			Williams & War	Pasader			Arunde1		
Funeral Director	5. Social Security Number 6. Security Number 10 10 10 10 10 10 10 10 10 10 10 10 10	T	yrs. last birthday) _ '3 Yrs.	Months Deys		8. Date of Birth (Month, Day, Y Feb. 14,	^(ear) 1925	9. Birthplece (S Country) Mary I an	State or Foreign	
and and	10a. State 10b. County	100	City, Town or Loc	ation				10d. Ins	side City Limits	
r 28a-1 show notified at	Maryland Anne A	cundel		Pasader	าล			1 [☐Yes 2 No	
or 28s	10e. Street and Number	dildoi		10f. Zip Code		10g. Citizen of Whet Country?				
23a o	8135 Tower Brid	ge Rd.			21122		USA			
al', or items examiner m by Funer	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decadent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	In U,S. 13. W	Vas Decedent of Yes, specify Cul ☐ Yes 2 X No	Hispenic Origin? (S) ben, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		a - American Ind ck, White, etc. White		
natural', edical Ex leted by	15. Decedent's Ed	ucation	16a. Decede	ent's Usual Occu	pation	king 16	b. Kind of Bu	usiness/Industry		
0	(Specify only highest grad	College (1-4or 5+)			during most of wor			ore City		
Cor Cor	10		Ground	s Keeper	Supervis			creation	15	
ISE A	17. Father's Name (First, Middle, Last)	nlov Dondl	011			ne (First, Middle, Ma		10)		
Mental arked or atic ever		nley Bradl	-		Sallie		111			
9 m =	19a. Informent's Name/Reletionship (T					ral Route Number, ()	
Haalth Hem 27 other tr	Kathleen Izdebski 20a. Method of Disposition	(Niece)	370_C	lover Ci	t. Glen Bu	urnie, Mar	ryland	21060 City or Town, St	tato	
5 O - 2	1 ☐ Burial 2 🂢 Cremation 3 ☐ I	Hemoval from State	Ob. Placa of Dispos cemetery, crem							
epartment or moortant: If ny injury or nos	4 Donation 5 Other (Specify,		Metro Cre	-		7/10/98 Ba	altimon	re, Mary	/land	
Departiment any in	21. Signature of Funeral Service Licens	···	A	_	ress of Facility S Funeral	Home PA Pasadena	Md	21122		
hysician /Medical ixaminer	Immediate Cause (Final disease or condition resulting In death)	a. Metast	at, C Co		sascomo	othe Left	SUNG		val Between of end Death	
cian and burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury									
as the	resulting in death) Last	d	to (or as e consequ	enca of):						
the attend hed for use /siclar/	Part II. Other significant conditions co	atributing to death but no	t requiring in the un	dorhdon nouse o	ihan in Bart I	23h Did toh	2000 1100 001	ntribute to the c	auge of death'	
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signed by d be defined d by Phy						, , , ,		001.0000.,		
shour ete						24a. Was an performe		24b. Were autavailable completic of death?	prior to on of cause	
ate has page 2						1□ Yes	2 No	1 □ Yes	21000	
cartificate has rector, page 2 Be Comp	25. Was case referred to medical				26 Place of Dec	eth (Check only one)	, (
this cartifloral director.	examiner?	Hospitel:	2 ER/Outpatient	3□ DOA O	ther: 4 Nursing H			er (Specify)		
aral di	27. Menner of Deeth	28e. Dete of Injury (Month, Day Yea		28c. Inj		28d. Describe how				
within 24 hours after death. To the Funeral Director: After this cartiflocomplately filled in by the funeral director. Medical Certification: To Be (1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, stre	M 1[Yes 2□No	28f. Location (Stre City or Town,		per or Rural Rout	le Number,	
within 24 hours after death To the Funeral Director: complately filled in by tha Medical Certificat	(Check only 2 Medical Exam	elclan: To the best of my lner: On the basis of exer	knowledge, death mination and/or invo	occurred at the sastigation, in my	time, date end plece opinion, death occu	, end due to the ceu rred et the time, dat	ise(s) end me e end plece,	enner as stated. and due to the c	euse(s)	
within 2 To the compla	one) 29b. Signature and tiple of certifier	and manner steted.	1	29a Linos	nse number	204	1 Date sions	d (Month, Day, Y	Year)	
1	* Chinal	Alks	Elas.	250. Licer	3/5	7 3	4 ly	P)	998	
6	30. Narke and eddress of person who c	ompleted cause of death	(Item 23a) (Type, F	HISLW.	Swite 60	12, G/p.	Burn	e. Nd. 2	106/	
State	31. Date filed (Month, Dey, Yeer)	32. Registrar's S		Dunda 90		,		,		

DHMH 16 Rev 6/95

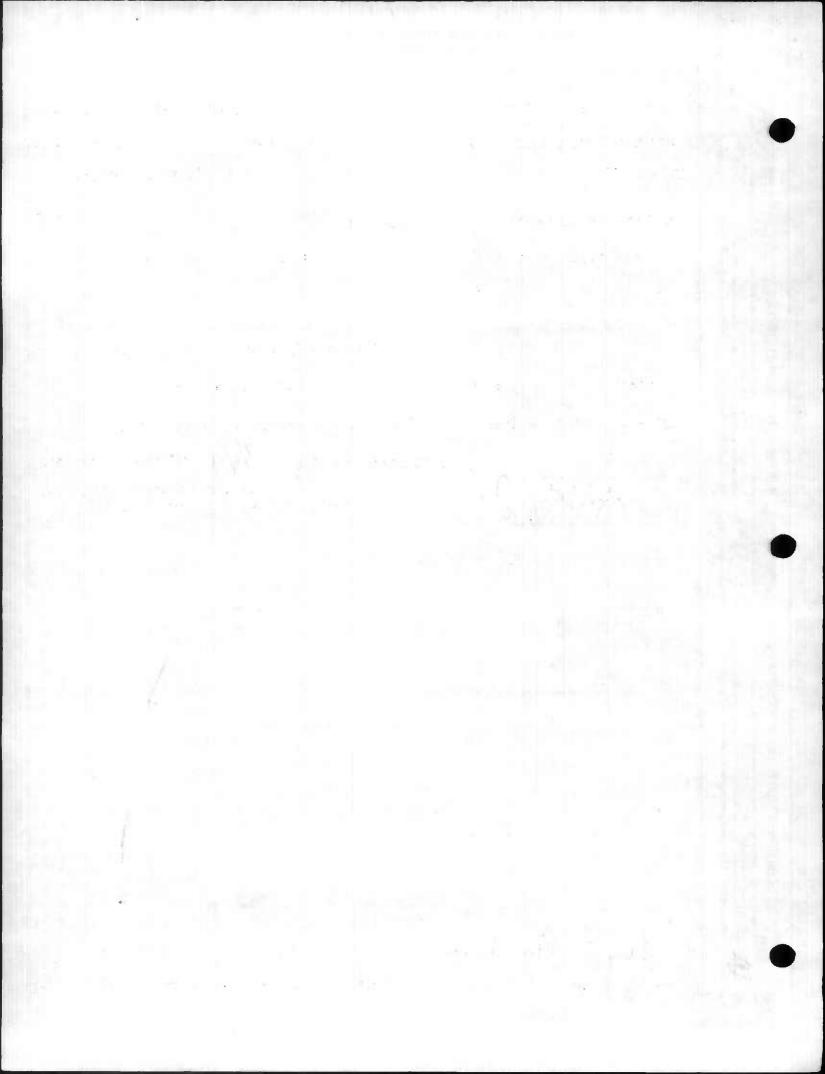


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

CLARK E. BOSTON

State of Maryland / Department of Health and Mental Hygiene 0 1 1 1 9

ITEMS: #								Reg. No. 2. Date of Death Month Dey Ye		3. Time of Death	
Phys /Me	içian dical	Clark E.	Boston	II				JULY (1, 1998	Year	0242AM
Exar		4a Fecility Name (If not institution				4	b. City, Town, or	Location of Deat	h 4c. County	of Death	
		NORTH ARUNDEL 5. Social Security Number		R. Age (In yrs. last bii	thday) If Und	er 1 Year	If Under 24 Hr				DEL COUNTY
Funer Direct		212-86-3592 Usuel Residence of Decedent	Mar	place (State or Foreign http)							
ylend		10a. State 10b. County		10c. City, Tow	n or Location					1	0d. Inside City Limits
a Mar	ctor	Maryland Anne	Arundel		Pasaden	a					1 □ Yes 2 No
ath with the Maryler 23s or 28s-f show ust be notified at rai Director	10e. Street end Number			10f. 2	ip Code			10g. Citizen of \	What Cour	ntry?	
ath w	a a	456 Nautical			140 144 - 5		21122	0	US	A	cen Indian,
filed within 72 hours a thyglena. ther than "natural", o and, the Medical Example to Completed by	by Funeral	11. Marifel Stefus 1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Wes Deceden Armed Forces 1 Yes 2 X If Yes, Give Yeer or Dates	?] No		ecify Cuba		Specify Yes or Norto Ricen, etc.)	Specify	ck, White,	
	15. Decedent (Specify only highes	s Education	16a	Decedent's Us	ent's Usual Occupetion ind of work done during most of working O NOT use retired)			16b. Kind of B	usiness/in	dustry	
	Elementery/Secondery (0-12)	College (1-4o	r 5+)			n Engine		Hoavy E	quin	Openator	
	12 17. Father's Neme (First, Middle, I	estl		ope	1 4 6 1 0			, Maiden Sumen		. Operator	
	Clark E.		n				Imbragu		,		
2 should be end Mental is marked o	5	19e. Informent's Neme/Relationsh	ip (Type, Print)	198	. Mailing Addre	ss (Street e			per, City or Town,	Stete, Zip	Code)
P 27		Lynne W. Bostor	- Mother						icum 210		
一工五五		20e. Method of Disposition		20b. Piece o	f Disposition (Nay, cremetory of	leme of		Date	20c. Location	City or To	own, State
permit. Pagas 1 ar Department of Hea Important: If Item; any injury or othe		4 Donation 5 Other (Sp	Inc.	16/9/ Baltimore, Maryland							
permit. Pa Departmen Important: any injury	SUCE	21. Signature of Funeral Service 1	pansee				s of Facility	2+a114ma			
70E # 8		Mad. S	(4)		3111	Moun	tain Roa	ad Pasa	s Funera	2113	ne, P.A.
		23a. Part1. Enter the diseese, or shock, or heart feilure. List of	complications that ceus only on cause on each	ed the death. Do line.	not enter the m	ode of dying	g, such es cerdia	ac or respiretory	errest,		Approximate interval Between
Physicia	_										Onset and Death
/Medica Examina	_	Immediate Cause (Finel disease or condition resulting in death) NARCOTIC AND A1COHOL INTOXICATION									
	ē E	Due to (or as a consequence of): Due to (or as a consequence of):									
betu d ansit	Examiner										
exec in an											
tificate be executed gothysician and as the bunal-transit	edicai										
\$ 0 a	900	resulting in death) Last	d.								
The law requiras that the death cert ite has been signed by the attending page 2 should be detached for use a	Physician/N		0.								
that the da ed by the a detached	ysic	Pert II. Other significant condition	23b. Did tobacco use contribute to the cause of death?								
that the detail								1	Yee 2 No	3 Pro	bably 4 Unknown
ulras i n sign	ed by								s an eutopsy	24b. W	ere eutopsy findings
w require s been si should	ojete							per	ormed?	CC	valiable prior to empletion of cause deeth?
The law ate has page 2	Completed							10	Yes 2□No		94es 2□ No
100	60	25. Was case referred to medical					26. Place of De	eeth (Check only			
Physician: this certific and director,	To B	examiner? 1⊠ Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 ER/O	utpatient 3 1	DOA Othe	251		idence 6 🗆 Oth	ner (Specia	ty)
Iling After		27. Menner of Death 1 Natural 5 Pending 2 Accident Investig	28a. Date of in FOUND 7 -		Time of Injury A	28c. Injun Work	yat ⟨? Yes 2∭No	28d. Describe	how injury occur	red	
l or Attanding after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☒ Could n 4 ☐ Homicide determi	28e. Plece of I	njury - At home, fa etc. (Specify) ARTMENT	arm, street, fact	ory, office		28f. Location (Street and Number or Rural Route I City or Town, Stete) 8228 FT. SMALL ANNE ARUNDEL COUNTY MD.		al Route Number, SMALLWOOD RD	
Hospital or 24 hours afte Funeral Dir stely filled in		29a, Certifier 1□ Certifying					o data and nine	1			
24 hr Fun	Medical		Physician: To the bes examiner: On the basis and manner:	of examination ar							
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier	A		2	9c. License	number		29d. Date signe	d (Month,	Dey, Year)
, de		Welling.	C.M.E.		JULY (3. 1	998				
190		30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)									
		MARGARIOS		er MM 1	11 Penn	Stre	et, Bal	timore,	Maryland	212	01
	tate	31. Dete filed (Month, Dey, Year)		strar's Signature	, 70	90					
Regi	strar	JUL 08	1330 P	Julia Davide	m-Navias						



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate the hearth care to hearth care in the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and person of the following physician in the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene print of burial compation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

Lewis

Coles

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

5x

	1 - STATE REGISTRAR		AND / DEPARTME CERTIFICA	NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEI						
	1. DECEDENT'S NAME (First, Middle, Last	TUNIS	COLE		2. DATE OF DEATH		AR 18:50 PM				
	4. SOCIAL SECURITY NUMBER 217-07-0260 9a. FACILITY NAME (If not Institution, give	1 M 2 D F	77 YRS. MONT			1920 M	BIRTHPLACE (State or Foreign Country) aryland				
TOR	Carroll County (Vestminster	DEATH	Carro					
DIRECTOR		e Arundel	10c. CITY, TOW	n or Location dena			10d. INSIDE CITY LIMITS? 1 YES 2 Y NO				
FUNERAL	106. STREET AND NUMBER 106. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF WHAT 108. STREET AND NUMBER 109. CITIZEN OF WHAT 108. STREET AND NUMBER										
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 V YES IF YES, GIVE WAR OR D	2 NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—II yea, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Black, Whita, atc. 1 □ YES 2 \(\) NO Specify: Specify:							
ETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	DUCATION de completed) College (1-4 or 5 +)	18a. DECEDENT'S USUAL (Give kind of work do life. Do NOT use retire	OCCUPATION ne during most of working d.)	16b. KIND OF BU	ISINESS/INDUST	White				
OMP	Specify only highest grade completed Glive kind of work done during most of working life. Do NOT use retired.) Prohet Food										
BE	Lewis T. Cole.Sr		19h MAII INC ADDR	Rheue	llen De For	d					
10	19a. INFORMANT'S NAME (Typer/Print) Randy B. Cole (Son) 2647 Robert Arthur Road Westminster Md. 21158										
20a. METHOD OF DISPOSITION Dariel 2 To Cremellon 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremelory or other place) Cremetery Cremetery Cremetery Cremetery Cremetery Cremetery Cremetery Cremetery T/8/98 Baltimore, Maryland											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MCCully-Polyniak Funeral Home 237 F. Patapsco Ave. Balto. Md. 21225										
	23. PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Finel	complications that caused. Liet only one cause on a	i the death. Do not an	ter the mode of dying, su	ch as cerdiac or reep	iratory errest,	Approximate Interval Between				
	disease or condition resulting in death)	Lui A	e Pen	enalory	failur	2	2 days				
NO	Sequentially list conditions, Description to learn date Description to le										
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	· Paul	CONSEQUENCE OF:	Tailure			0				
CERTI	resulting in death) LAST	d									
MEDICAL	PART II. Other algnificant condition	ne contributing to deeth b	ut not resulting in the	underlying cause given is	1 Part I. 24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?				
AN: N	25. WAS CASE REFERRED TO MEDICAL						1 TYES 2 NO				
YSICI	EXAMINER? 1 YES 2 NO	HOSPITAL:	etient 3 DOA 4 h	26. PLACE OF OEATH (C ER: tursing Home 5 ☐ Residence							
BY PHYSICIAN:	27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Yeer)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE HOW I	NJURY OCCURE	0				
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Speci	At home, larm, street, l	ectory, office	281. LOCATION (Street and Number or Pural Route Number, City or Town, State)						
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS	SICIAN: To the best of my knowl ER: On the basis of examination	edge, death occurred at the	time, data and place, and du popinion, death occured at the	a to the cause(a) and mar s lime, data and place, an	nner ee stated.	se(s) and manner as stated.				
BE	296. SIGNATURE AND TIPLE OF CENTIFIE			29c. LICENSE NU			YED (Month, Day, Year)				
٩	30. HAME AND ADDRESS OF PERSON YE	FRE IS		Stones	Aue	mest	unstanto				
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA			,		21157.				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month MA 00° hen JU! 4a. Facility Name (If not institution, give streat end number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTO 5. Sociel Security Number VIEW Special are If Under 24 Hrs. 8. Date of Birth Hours Min. OCT 5, 1963 if Under 1 Yaar 6 Sex 7. Age (In yrs. last birthdey) 34 yrs Birthplace (State or Foraign Country) PA Months Deys 1X M 2□ F 220-86-0771 Yrs. Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTO MD TV Wes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21231 U.S.A. 110 N. CHAPEL ST 11 Marital Statue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Rece - Amarican Indian, Biack, White, etc. 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Never Merried 2□ Married 1 Yes 2 XNo Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12th College (1-4or 5+) MAINTANENCE WORKER MAINTANENCE CO yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) GEORGE COPES MARY WILLIAMS 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MARY COPES 110 N. CHAPEL ST BALTO, MD 21231 20e. Method of Disposition 20b. Piece of Disposition (Neme of 20c. Location - City or Town, Stete cemetery, cremetory or other ple GREENMOUNT CEM 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 7-7-98 BALTO, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Service Licensee 22. Nama and Address of Fecility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD u aa 21213 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errast, shock, or heart failure. List only one cause on each line. Intervs! Bet Onsat and Death Immediate Cause (Finel disaese or condition resulting in death) . DISSEMINATED INCOBACTERIUM AUIUM COMPLER INFECTION MUTHS Due to (or es e consequence of): 6 ACQUILED IMMUNDREFICIONLY SYMPROME YEARS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): · HUMAN IMMUNO REFLICITY VIRUS INFERM ON YEARS Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy completion of cause of deeth? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Depertment of Health er Important: If item 27 is any injury or other trau

Physician

/Medical

Examiner

Director

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Completed

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Funeral

Director

show

28a-f

238

or items

natural',

end Mental Hygiene. Is marked other than

traumatic event, the Medical Examiner must be notified at

the Maryland

with 6

filed within 72 hours after

Pages 1 and 2 should be

21215-0020

Baltimore, Maryland

The law requires that the death certificate signed by 90

Box 68760

P.O.

Records,

of Vital

Division

has this certificete After Attending death.

Physician/Medical þ Completed Be 2 Certification: P

Examiner Medical 29b. Signeture and le of certifiar

or Attendent efter death Director: A Hospital To the Hosp within 24 hor To the Fune completely fi

Registrar

Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. HOPANTIS C YRUS INFECTION MULTIFACTURIAL ROWER WSUFFICIONSY HUMAN IMMUND DEFCIENCY UNUS ENCEPHALOGRAPHY 25. Wes cese referred to medical exeminar? 26. Plece of Deeth (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Oulpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner steted. 29a. Certifier (Check only

29c. License number

29d. Date signed (Month, Dev. Year)

20051957 30. Name and address of person who completed cause of death (Hem 23e) (Type, Print) Suite 407.

HUSTOLITED F. CARENTEN M 1850 1830 EAST MONUMENT, BALTIMITE, MY 21205

31. Data filed (Month, Day, Yeer) JUL 097998

A Tardon

Statement was sampled by

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Amend: #1 Per MD Film G761 7-9-98RC Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Month MARY MARCIA CLAEYS June 30, 1998 4:15 PM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Green Acres Group Homes Silver Springs Montgomery 8. Data of Birth (Month, Day, Year)
Nov. 28, 1929 Maryland If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1□M 20 F Days Hours 577-40-3780 68 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avent, the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Maryland Director Montgomery Silver Springs 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 14911 New Hampshire Avenue USA 20905 Івта 23а Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter. Department of Health and Mental Hygiene. Important: If fem 27 la merked other than "natural", or that any injury or other traumatic event 1 Navar Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Give Year or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ₺No à Specify: WHITE 315€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementary/Secondary (0-12) Telephone Operator Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Vincent Allred Eugenia Kraus 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Claudette Reese/sister 35 L. Ridge Road, Greenbelt, Maryland 20770 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20s. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☑ Donation _5 ☐ Othar (Specify) Jade Director 21. Signature of Funeral Service License Ronald S ²² Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Baltimore, Maryland 21201

Fant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, nock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause /Final K & DITA diseasa or condition resulting in death) wee Examiner Due to (or as a consequence of Examiner 9 attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, rollaren The law requires that the death certificate be Physician/Medical Due to (or as a consequenca of): Part fl. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part f. the 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Unknown olmon on Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? peed page 2 s has 1 Yes 1 Yes certificate a 10841 C or Attanding Physician: director. Be 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending within 24 hours efter death.

To the Funeral Director: Al
completely filled in by the fu 1 Yes 2 No Invastigation 2 Accident 6 Could not be determined 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 3 Sulcide 28e. Placa of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certiflei Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and mannar statad. To the within 2 29b. Signature and titla of cartifique 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATRICIA 09 7) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

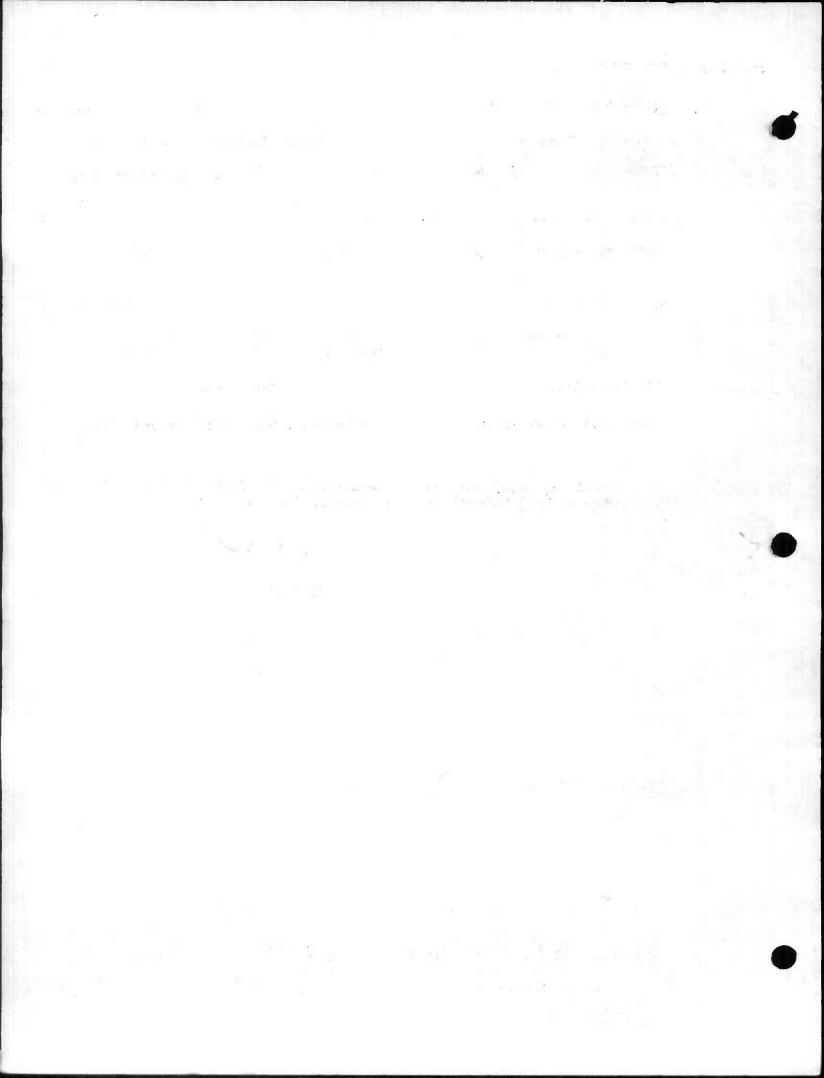
Julia Davidson

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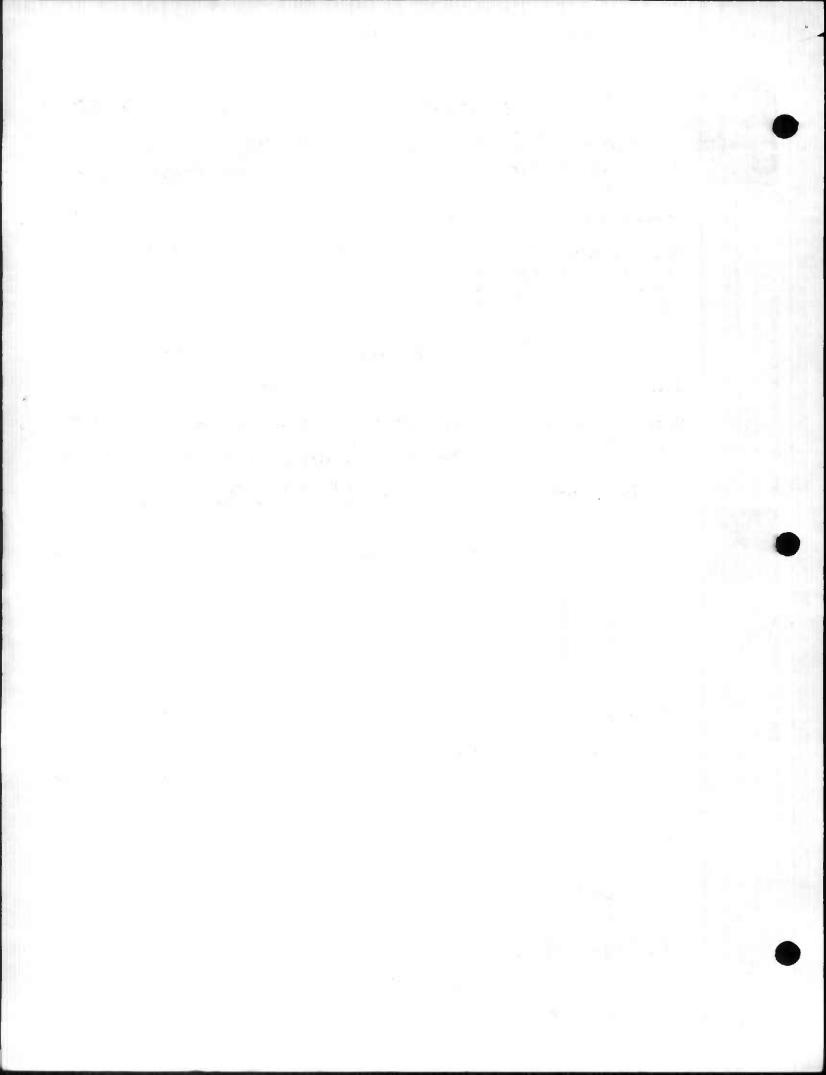
DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death

						Cert	ificate (of Dea	th	1	Reg. No	9	8 2	1023
	Physic	ian	1. Decedent's Neme (First, Middle, L.	A 1						2. Dete of De Month	eth De	v	Yaer 3	3. Time of Death
	/Medi		Peula		Ver7					JULY	6	10	198 H	38179
ΔĮ.	Examir	ner	4a. Fecility Neme (If not institution, gi	ve street end number) MARITAN	1/00	0-1				ocation of Deat		County	of Death	
					MUS	PITAL ast birthday)	If Undar 1 Y		TMOR dar 24 Hrs.			Ñ/A	a District	(0)
à	Funeral Director			1□ M 2ØF	103	Yrs.		ays Hou		8. Data of Bir (Month, De APRIL	5 /8	95	Virgi	a (Steta or Foreign nia
pue	M 18		10e. Stete 10b. County		10c. City,	Town or Loc	ation						10d.	Inside City Limits
Man	5 5	to	Maryland N/A		Balt	timore								1 ▼Yes 2 No
the the	or 28	lrec	10e. Street end Number				10f. Zip Co	de			10g. Cif	izen of W	hat Country	?
3	23a	Funeral Director	6000 Bellona Aver	nue			2121	2			Unit	ted S	States	
r des		une	11. Marital Status	12. Wes Decedant Armed Forces? 1 ☐ Yes 2 📉	Evar In U,S	5. 13. W	as Decedent Yes, specify	of Hispanic Cuban, Mexi	Orlgin? (Sp can, Puerto	pecity Yes or No Rican, etc.)	>-		- Amarican	
21215-0020 d within 72 hours after death with the Mandand	Department of Health and Mental Hygiene. Important: or flems 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner name be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 📉 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🐧 I If Yes, Give Yeer or Deles:	If Yes, Give 1 ⊔ Yas 2 X No Specify:						4	Specify:		
5-6	disa	etec	15. Decedent's E (Specify only highest gr	ducation ade com <i>pleted)</i>		16e. Decede (Give k	nt's Usual Or ind of work do O NOT use re	ccupation one during n	nost of wor	king	16b. K	Ind of Bu	siness/Indus	lry
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Baltimore	Department Important: If any injury or once.		1 ABuriel 2 □ Cremetion 3 E 4 □ Donetion 5 □ Other (Speci	(y)		id Rida	ge Cem	etery	1	7/9/98			re, Ma	ryland
Balt Pemit	Depa Impo any Ir		21. Signeture of Funerel Service Lica	Signeture of Funerel Service Licansee 22. Nama and Address of Fecility Mitchell-Wiedefe 6500 York Road									and 2	1212
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	/Medicai xaminer		Immadiate Cause (Final disease or condition resulting in death)	е. /	Neu	MON	IA						h	dAVS
		<u>_</u>	resulting at death)		Due to (or	es e consequ	enca of):							
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Box death cer	endir r use			3.										
· 9	he at	Physician/	Part II. Other significant conditions	contributing to death be	ut not rasult	ting in the und	derlying cause	e given In Pe	ert I.	23b. Dld	tobacco	use con	tribute to the	e cause of death?
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	h. After t funera	inol inol	27. Manner of Deeth Netural 5 Pending	28a. Dete of Inju (Month, De)	y Year) 2	28b. Time of Injury		Injury et Work?		28d. Describe	how Inju	ry occurre	ed	
Vision	efter death Director: A in by the f	cat	2 Accident investigation 3 Sulcide 6 Could not be	00 - Disease (in)	unu. At hom	na farm atra-		1 ☐ Yes 2	□No	28f. Location (Street or	od Alumba	e or Pural P	outo Alumbas
5 6	efter deatl Director: J in by the	Certification:	4 ☐ Homloide determined 28e. Pleca of injury - At home, ferm, street, factory, office building, etc. (Specify)							City or To			ii oi nuiai n	oute reuniber,
Hospita	within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical C	29a. Certifier (Check only 2 Medical Example)	nysician: To the best of minar: On the basis of	examination	ledge, death on end/or inve	occurred et the	ne time, dete	end plece, deeth occur	, end due to the rred et the time,	ceuse(s)	end mer d place, e	nner es stete	d. a cause(s)
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	-		20 Name and address of a second	anny	eath /h	00-1 (7 -		107			Juc.	16,	1777)
1			30. Name and address of person who	Completed cause of d	IOO 7	ZJa) (Type, P	o DD	Un	no d	le GRA	no	Un		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ammend #4 Per FH Film G761 7-15-98 rja Certificate of Death Reg. No. 3. Time of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) **Physician** WILLIAM JUL DUNCAN 4 1998 unknown /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACILIXORE BALTEMORE CET If Under 1 Year If Under 24 Hrs. 5, Sociei Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**X**XM 2□ F SOUTH CAROLINA 216-16-3602 79 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or flems 23s or 28s-f show the Medical Examiner must be notified at 1 X Xes 2 No Director MARYLAND BALTIMORE CITY N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 21215 3610 CEDARDALE ROAD U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? X∆IYes 2 □ No IYes, Give Year or Dates:43/46 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: BLACK 1 Yes 2XXIIo Specify: þ X Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementery/Secondary (0-12) College (1-4or 5+) WESTERN ELECTRIC 11th grade MACHINIST 18. Mother's Name (First, Middla, Maidan Sumame) 17. Father's Name (First, Middla, Last) LEWI WILLIAM DUNCAN JULIA JOHNSON 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rebecca Duncan/Daughter 3610 Cedardale Road, Baltimore, Maryland 21215 20b. Place of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Bunal 2 Cremation 3 Removal from State 6 GARRISON FOREST VETERANS 7-10 OWINGS MILLS, MARYLAND 5 Other (Specify) any injury 4 | Donation 22. Name and Address of Facility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last ANTENIOSCLENOSZS Physician/Medical USB Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco-use contribute to the cause of death? signed by t 110 20 No 3 Probably 4 Unknown DEMENTIA. 2q 24b. Were autopsy findings available prior to & THE KNEE AMPUTATION 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2534 1 ☐ Yes 2 ☐ No 25. Was case referred to most examiner? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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permit. Pages 1 end 2 Department of Health a Important: If item 27 is

altimore, Maryland 21215-0020

within 2

State Registrar

Medical

PHPARKHEIGHT 31. Date filed (Month, Day, Yaer) JUL 0 9 1998

29e. Certifier

(Check only one)

32. Registrar's Signature Aulia Davidson

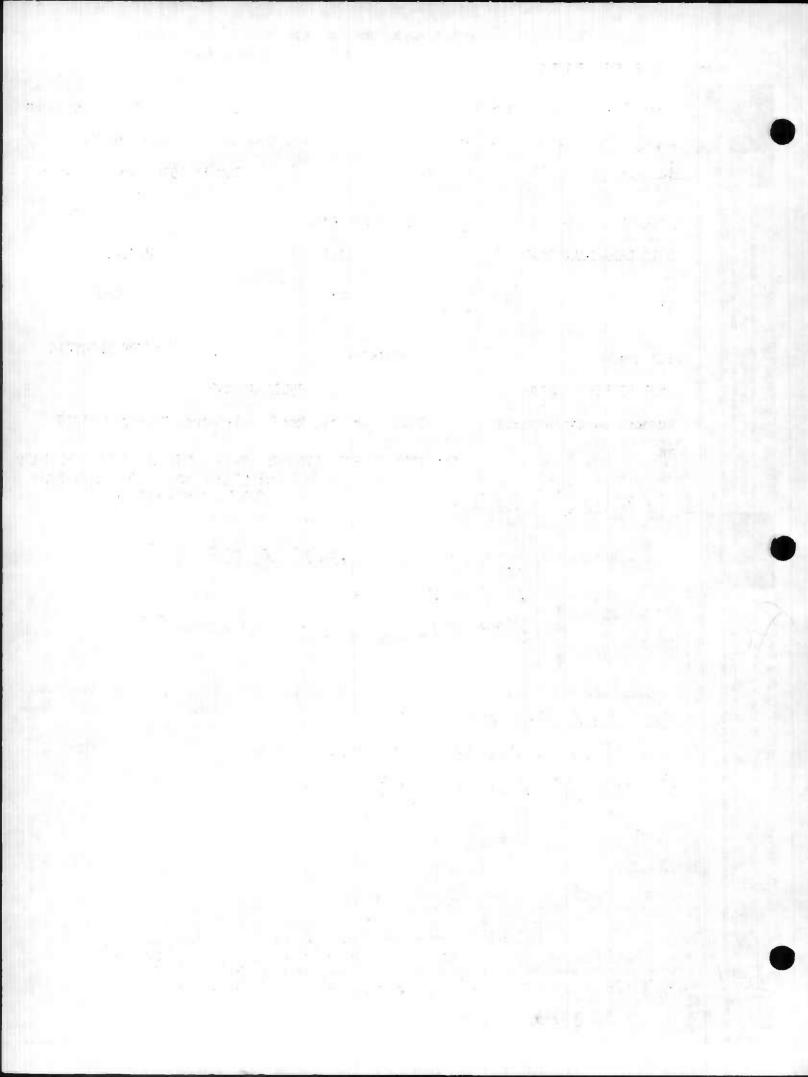
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTITY

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Certificat	e of	Death		Re	g. No.	files	1 0 60	,
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hysician /Medical	Robert Adam E	lliott						May	23	1998	11:10) am
xaminer	4a Fecility Nema (If not institution, given					4b. City, To	wn, or L	ocation of Death	4c. Count	of Death		
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neral ector		Sex 7. Age 1∭ M 2□ F	e (In yrs. lest birt	hday) If Under Months	1 Yeer Deys	Hours	24 Hrs. Min.	8. Dete of Birth (Month, Dey, Sept 1,	Year) 1916	9. Birthp Cour	olace (Stete ontry) MD	r Foreig
ž ==	10a. Stete 10b. County		10c. City, Town	or Location						1	0d. Inside Ci	ity Limits
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Department of Health and Mental Hygiena. Department at 1 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	MD Garr	ett	Kit		0.000		1X Yes	2 N				
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any Inju	21. Signature of Fureral Service Licensee 22. Name and Address of Fecility David A. Burdock Funeral Home 710 Church Street, Kitzmiller, MD 23a. Part. Enter the disease, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory errest,										21538 Approximat	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) Month Ellerbe **Physician** Gai 1 JULY 9, 1998 02:15 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY BA
If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year) JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 6. Sex **Funeral** Months Deys Hours 1 M 2 F 218-60-2668 Yrs. 44 Director 06-07-54 MD Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at MD Yes 2□No NA Baltimore Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 1208 Ensor Street 21202 USA Pagas 1 and 2 should be filed within 72 hours aftar death vent of Haalth and Mental Hygiana.
whit if them 27 is marked other than "natural; or items 23 any or other traumatic event, the Medical Examine mail ury or other traumatic event, the Medical Examine mail Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian. 11. Marital Stetus Bieck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Attorney Kaplan Office Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Accountant 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Name (First, Middle, Last) James Ernestine Kearney J. Yarborough 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. informent's Name/Reletionship (Type, Print) Ernestine J. 1208 Ensor Street Baltimore, Maryland Kearney 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition permit. Pagas Department of Important: If it any injury or o 1 XBuriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. Cem. 07-13-98 Randallstown, Md 22. Name and Address of Facility Baltimore, Maryland 21202 o of Funeral Service Licenses WM.C. March FH 1101 E. North Avenue West Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Ceuse (Final disease or condition resulting in deeth) Disseminated mycobacteria Examiner Due to (or es e consequence of): Virus Infection Physician/Medical Examiner Immunodeticiency attanding physician and for use as the burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) Records, P.O. Box 68760, thet initiated events resulting in death) Lest Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cachexia þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was an eutopsy performed? Completed has cata ha Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28d. Describe how injury occurred 27. Menner of Death 28e. Dete of injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Naturai 2 ☐ Accident 1 Tyes 2 No or Attent after deal Director 6 Could not be 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or A within 24 hours after To the Funerel Direcompletaly filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) end menner as stated.

Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, end due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 290. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

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physician

State Registrar

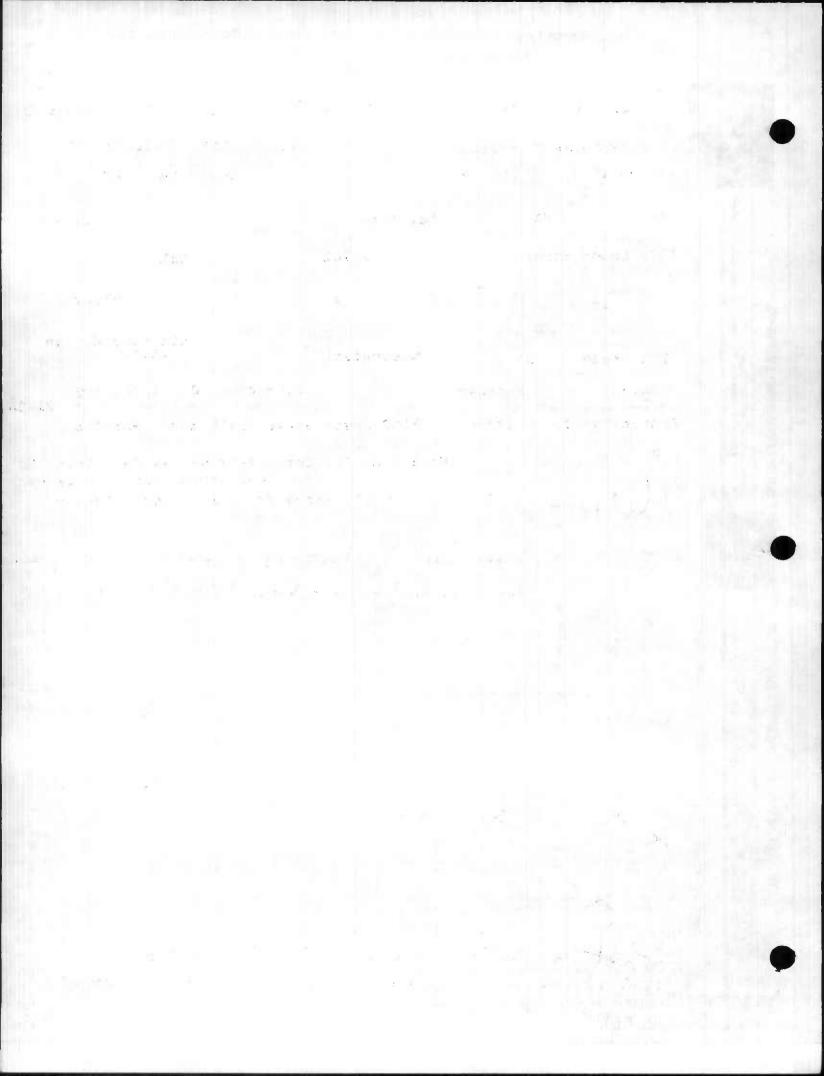
Johns Hopkins Hospital 32. Registrar's Signatura 31. Date filed (Month, Day, Year)

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GY, H. Y.

Resident

rson who completed ceuse of death (ttem 23a) (Type, Print)



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State of Maryland / Depa

	2. Date of Deeth		3. Time of Death
rtificate of Death	Reg. No.	20	41021
artment of Health and M	Mental Hygiene	98	21027

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Funeral Director

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7 is marked other than "natural", or Nems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 2 should be filled within 72 hours after on and Mental Hygiena.
Is marked other than "natural", or iter Baltimore, Maryland 21215-0020 Pages 1 and 2 s nent of Health an other 1 8

Department of Important: If eny Injury or **Physician** /Medical **Examiner** physician and the burial-transit of Vital Records, P.O. Box 68760, certificata be 60 950 ō signed by the a peed has certificate this Certification: edical To the within 1 To the 1

Month 07, Antonio Maurice Faulkner JULY 1998 9:53P.M. 4b, City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) SHOCK TRAUMA CENTER BALTIMORE NA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 1 M 2 □ F Yrs. 218-96-2102 17 03-18-81 Md Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore Nayes 2□No Director 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2003 Jubilee Court 21214 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 2 Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Unemployed 9th Grade Laborer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Faulkner Roger Μ. Elouise Gause 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 1 4 19a. informant's Name/Relationship (Type, Print) Eloise Gause 2003 Jubilee Court Baltimore, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 & Buriel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. Cem. 07-11-98 Randallstown, Md. 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature di Funeral Service Licensee WM.C.March FH 1101 E. North Avenue Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Physician/Medicai that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 2 No 10 Yes 2□ No Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 2 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 7-7-98 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

28c. injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. License number

O.C.M.E.

1 Yes

Location (Street end Number City or Toyng, Stete)

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Dev. Year)

JULY 9,1998

2100

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

31. Date filed (Month, Dey, Year) 091998

LARON

5 Pending

Investigation

6 Could not be determined

1 Natural

2 Accident

3 ☐ Sulcide 4 Momicide

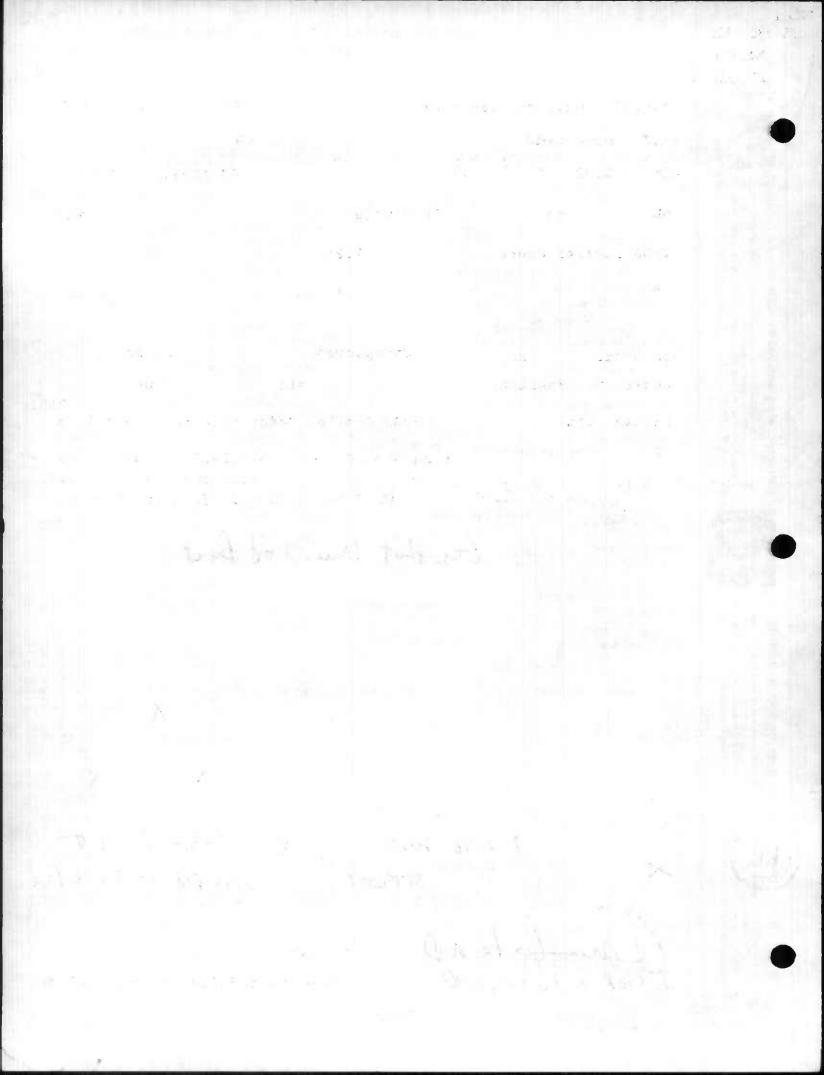
29b. Signature end title of certifier

29a. Certiflec

(Chec

32. Registrar's Signature Likia Davidson

and address of person who completed cause of death (them 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth 3. Tima of Death JULY 6 1998 6:55 AM MARIE KATHERINE FRIEDEL 4b. City, Town, or Location of Daeth 4a Facility Nama (If not institution, giva street end number) 4c. County of Death ANNE ARUNDEL COUNTY GLEN BURNIE MARINER HEALTH OF NORTH ARUNDEL 8. Data of Birth (Month, Day Sept. 5 If Under 24 Hrs. If Undar 1 Yaar 9. Birthplaca (Stata or Foraign 5. Social Security Number 7. Aga (In yrs. last birthday) Deys Hours 1 M 2 F Months Maryland 82 215-01-8013 Usuai Rasidance of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits Anne Arundel Co. Pasadena Md. 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? USA 21122 1232 Rock Hill Road 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 No If Yas, Giva Was Decedani of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Race - American Indian 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married white 1 ☐ Yas 2X No Specify: Specify. 3 XWidowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highast grada complated) Westinghouse Factory Elementary/Sacondary (0-12) Collaga (1-4or 5+) Assembly Line Worker 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Katherine Sch1em Louis Balling 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 1232 Rock Hill Road, Pasadena, Md. 21122 Sharon F. Bonner (Daughter) 20a. Mathod of Disposition Placa of Disposition (Nama of camatary, cramatory or other placa) Data 20c. Location - City or Town, Stata 1 X Burial 2 Cramation 3 Ramoval from State 7-8-98 Baltimore, Md. Oaklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22, Nama and Addrass of Facility McCully-Polyniak Funeral Home 21. Signeture of Funeral Sarvice Licens 3204 Mountain Road, Pasadena, Md. 21122 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Betwaen Onsat and Death Immadlata Causa (Final disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Disaase or Injury that initiated evants resulting in deeth) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings availeble prior to 24a. Was an autopsy

Physician /Medicai Examiner

ortant: H i

permit. Page Depertment of Important: If any Injury or once.

Physician

/Medical

Examiner

Funeral

Director

"naturel", or items 23a or 28a-f ehow adical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with in the heart of Health and Mental Hygiene. Int: If flem 27 is marked other than "naturel; or flems 23a or intry or other traumatic event, the Magical Examinating mail the response to the page of the page of

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

the Maryland

Physician/Medical Examiner signed by the a þ Completed

Be

Certification: To

edicai

The law requires that the death certificete bef been si i certificate has t papital or Attending Physician: hours after death. Ineral Director: After this certifica funeral director the Funeral Director filled in by the Hospital

Division of Vital Records, P.O. Box 68760

Part II. Other significant conditions contributing to death but not 25. Was casa rafarred to madical axaminar?

complation of cause of death? 1 Yas 2 No 26. Placa of Daath (Check only one) Other: Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Describe how Injury occurred

1 Naturai	5 Panding
2 Accidant	Invastigation
3 Suicida 4 Homicida	6 Could not be datarmined

28a. Data of Injury (Month, Day Year)

3 DOA 1 Inpatiant 2 ER/Outpatient 28b. Tima of

28c. tnjury et Work? 1 Yas 2 No 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta)

29a. Cartifiar

1 Yas

Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. Licansa number

29b. Signetura and titia of certi 30. Nama and address death (Itam 23a) (Types Print)

29d. Data signed (Month, Day, Year)

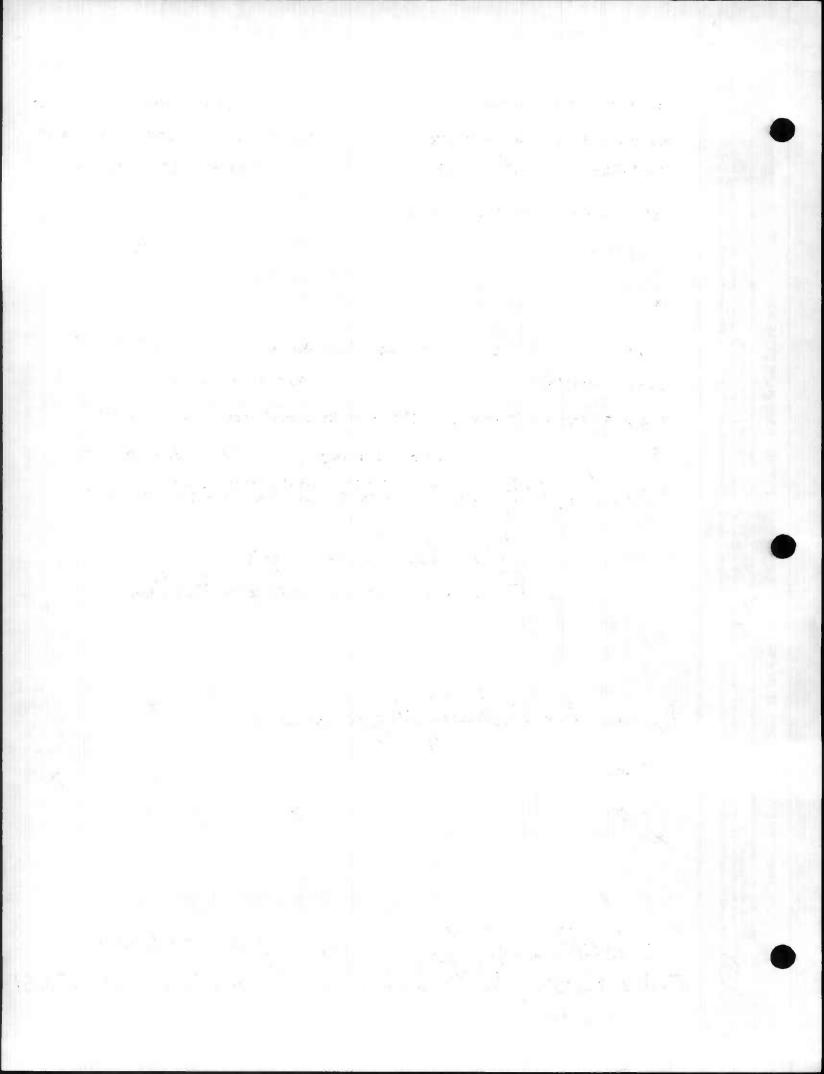
31. Date filed (Month, Day, Yaar)

09199

32. Registrar's Signatura

Registrar

To the Fune completely f within 2 To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #1 Per MD Film G761 7-9-98RC Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 40 **Physician** ETHEL M. GABODA 98 06 * /Medical 4b. City, Town, or Locatton of Death 4c. County of Death 4a Pacifity Name (If not institution, give street end number) Examiner Anne Arundel Co. Annapolis Annapolis Nursing and Rehab. Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV • 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** 01-9653A Months Days Hours 1916 1 ☐ M 212 F West Virginia 81 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Md. Anne Arundel Co, Pasadena Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21122 7809 Bodkin View Drive USA death Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian 11. Maritat Status Black, White, etc. 2 should be filed within 72 hours efter on and Mental Hygiene.

Is marked other than "natural", or ite 1 Never Married 2 Married white Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Etementery/Secondary (0-12) Packer Loreal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Bradas George Murnyak 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) permit. Pages 1 end 2 st Department of Health and Important: if item 27 is in any injury or other traun 7809 Bodkin View Drive, Pasadena, Md. 21122 (Daughter) Carol A. Cox 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) July 7 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removat from State Green Mount Cemetery 1998 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ²² Name and Address of Facility ak Funeral Home 3204 Mountain Road, Pasadena, Md. 21122 23a. Part1. Enter the disease, of complications that ceused the deaths bords enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical fmmediate Cause (Final disease or condition resulting in deeth) nyara Examiner moe of: Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last es a consequence of): physician Division of Vital Records, P.O. Box 68760. Physician/Medicai the Due to (or as a consequence of): ettending signed by the e 23b. Did tobacco use contribute to the cause of death? Part tl. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 3 ☐ Probably 4 🕅 Unknown 1 Yes 2 No 2 24b. Were autopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy Completed has certificate 1 ☐ Yes 2. No 1 Yes 2 No or Attending Physician: after deeth. Director: After this certifica 25. Was cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Dete of injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcide 6 Coutd not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner es stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier Medicai

29c. License number

29d. Date signed (Month: Day, Year)

Dr. Annapolis, hed. 2140

State Registrar 29b. Signature and title of certify

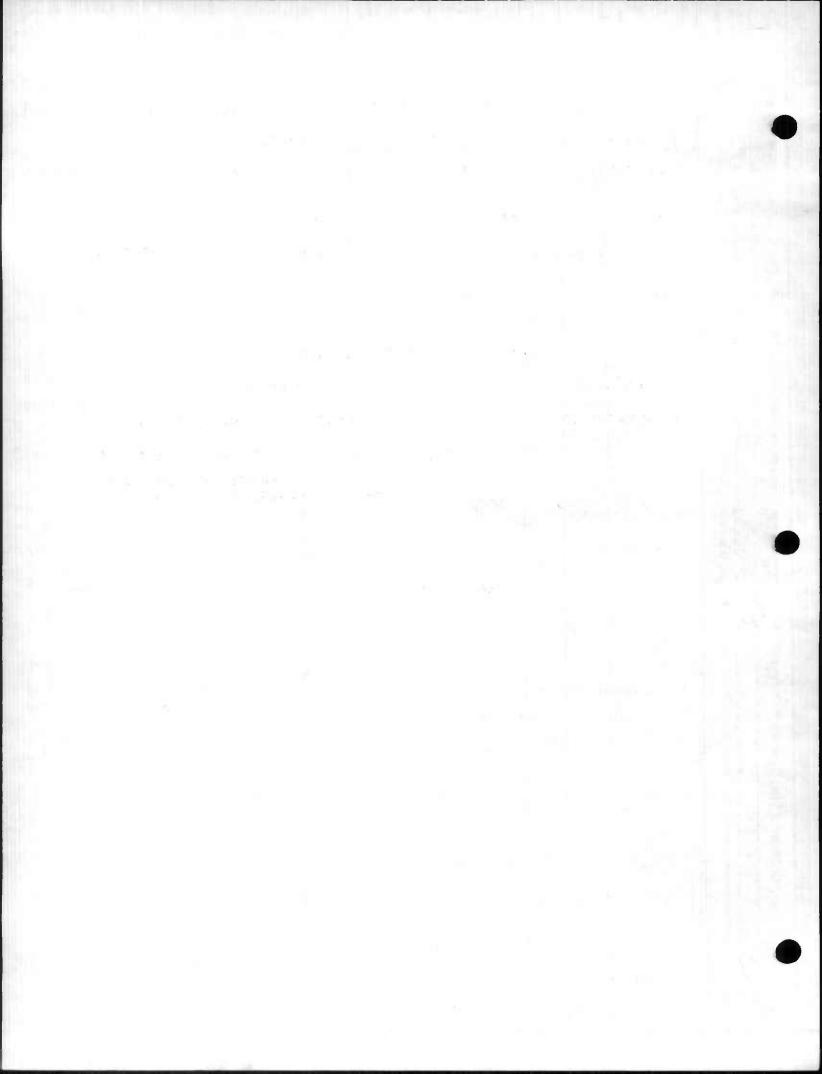
of person who completed ceuse of death (ttem 23a) (Type, Print)

Registrar's Signature

hman,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			State of Marylar		ent of Health and ate of Death		giene 9 8	21030		
Physi /Med Exam Funera Directo	dical siner	5. Social Security Number 6. S	Marie e street and number) an Khord /	Varging Hun last birthday) Mont	BALTO	2. Date of Deathor Location of Death	Day Ac. County of N, Year)	3. Time of Death 9. Death A 9. Birthplace (State or Foreign Country) PUERTO RICO		
Maryland H show	tor	10e. State 10b. County MD	N/A	ty, Town or Location	BALTO			10d. Insida City Limits 1 ☐ Yas 2 ☐ No		
ith the	Director	10e. Street and Number		10f.	Zip Coda		10g. Citizen of Wh			
seth w	eral	5009 FRANKFO	RD AVE 12. Was Decadent Evar in U	C 42 Was Da	21206	(Consider Van en No		S . A .		
15-0020 72 hours after deeth with the Manjand *natural*, or items 23s or 28s-f show edical Examiner must be notined at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armad Forces? 1 Yes 2 No If Yes, Give Yaar or Dates:		cedent of Hispanic Origin? specify Cuban, Mexican, Pu- s 2 XNo Specify:	erto Rican, etc.)		White, etc. BLACK		
21215-0020 d within 72 hours at giene. In then "natural", or the wed relieved.	Completed	15. Decedant's Ed (Specify only highest gra Elemantary/Secondary (0-12)	de completed) College (1-4or 5+)		work done during most of v Tuse retired)	vorking	16b. Kind of Busi			
aryland should be file ad Mental Hy marked othe imatic event.		7th 17. Fathar's Name (First, Middle, Last)	N/A	HOSPI	TAL AID	lame (First, Middla	HOSP:			
	To Be	UNKNOWN 19a. Informant's Name/Relationship (7)		19b. Mailing Addr	UNKN	OWN				
Te, Ma Tend 2: Heelth ar am 27 is other trau		MARGUERITA WEB			ARIEN RD		MD 2120			
Pege nent o nt: If		20a. Method of Disposition 1	Removal from State 7 D	m State ARBUTUS MEM PK 7-7-98				20c. Location - City or Town, State BALTO, MD		
Baltim permit. Peg Depertment Important: I any Injury o		21. Signature of Fundral Service Licen	OME D 21213							
Physician /Medica	i	23a. Part I. Enter the disease, of compshook, or heart failure. List only of immediate Ceuse (Final disease or condition				liac or raspiratory a	rrast,	Approximata Interval Batween Onset and Death		
Examine	120	resulting in death)	Due to (c	or as a consequence	of):					
be executed sician and buriel-transit	Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury	0.	or as a consequence				Years		
687 fficate p phys	Physician/Medical	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (o							
death cert e ettending of for use	iciar	Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlyin	23h Did	3h Did tohacco use contribute to the cause of death?				
T 5 7 5	by Phys		disorder	osing in the arreary		old tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown				
aw requires been seen seen seen seen seen seen se	Completed					an autopsy ormed?	24b. Ware autopsy findings available prior to completion of cause of daath?			
- F # &						10	Yes 2K No	1 ☐ Yes 2 ☐ No		
Vital I	o Be	25. Was case referred to medical axaminar? 1 ☐ Yes No	Hospital:		Othor	Death (Check only				
Phys rald	H-	1 Yes 2 No 27. Manner of Daath 1 Natural 5 Pending 2 Accident investigation	28a. Date of injury (Month, Day Year)	28b. Tima of Injury M	28c. Injury at Work?	Home 5 Resi 28d. Dascribe	denca 6 ⊡Other how injury occurred			
	Certification:	3 Suicide 6 Could not be determined						or Rural Route Number,		
Di To the Hospital or within 24 hours efte To the Funeral Dir completely filled in	edicai	29a. Certiflar (Check only one) Certifying Phy Description of the control of the	ysician: To the best of my kno niner; On the basis of examina and manner stated.	wledga, death occurr tion and/or Investigat	ed at tha tima, data and pla ion, in my opinion, daath oc	ce, and dua to tha courred at the time,	causa(s) and man date and place, an	nar as stated. d due to tha cause(s)		
To the vithin 2 To the comple	Σ	29b. Signatura and title of certifier	3	ale o	29c. Licensa number			(Month, Day, Year)		
1		7 7	o sano		040480	5	doly	6,1998		
//		30. Name and addrass of person who o	complated cause of death (Item		240480 7672 30 Balto,	MD	2/236	6, 1998		
Si Regis	ate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture						



ADH 98-3848-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ()

Certificate	of I	Doath	

JULY

6, 1998

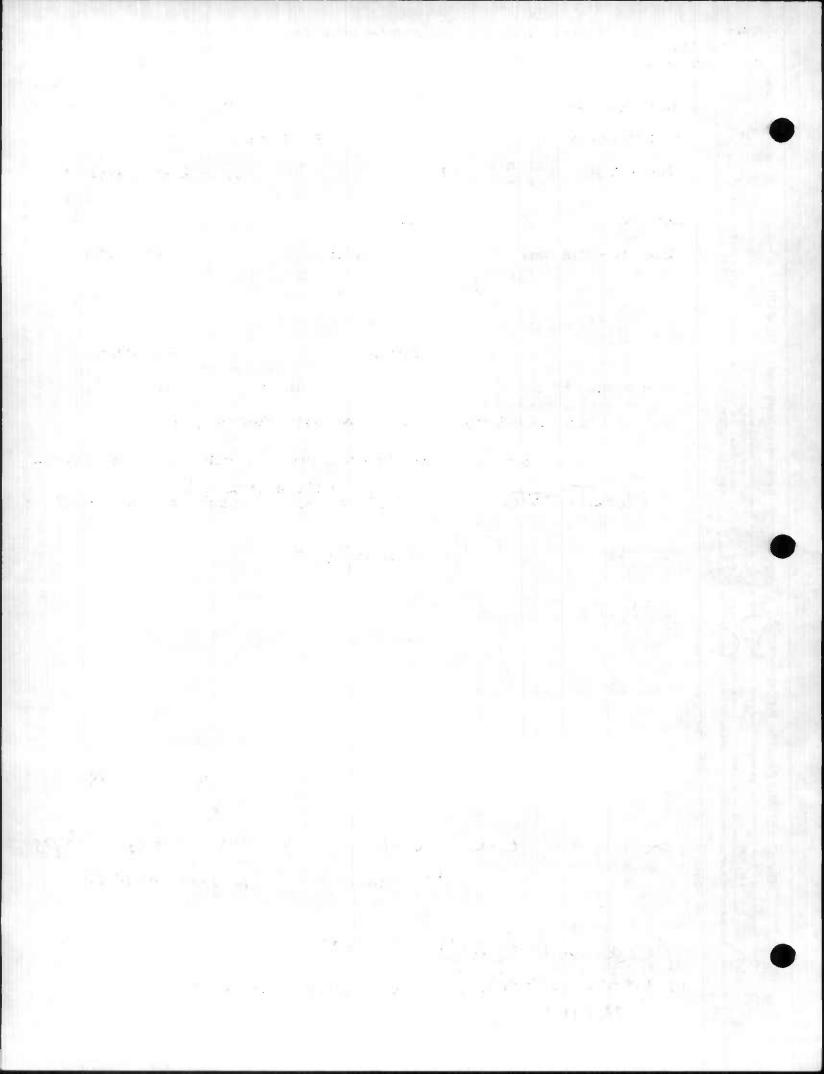
IAINE	I. HTHM			Cei	rtificate of	Death		Reg. No.	, 4	1001	
	1. Decedent's Neme (First, Middle,	Last)		237				2. Dete of Deeth Month Dey Yeer		3. Time of Death	
içian dical	Mary Janet Hihr	i					JULY		998	1406 PM	
niner	4e Fecility Name (If not institution,	give street and nu	mber)			4b. City, Town, o	r Location of Deat	h 4c. Count	y of Death		
	1509 GREENDALE	ROAD				BALTIMO	RE .	N/A			
al	5. Social Security Number	6. Sex	7. Age (In yrs.	lest birthday)	Months Days			th v. Year)	9. Birth	plece (Stete or Foreign	
	214-40-5278	1□ M 2 X F	89	Yrs.	Working Buys	710210	October	27 1908		land	
	Usual Residence of Decedent									104 1 14 02 1 2	
_	10a. Stete 10b. County				cation					10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
200	Maryland N/A		Bal	timore						A	
Funeral Director	10e. Street end Number	n 1			10f. Zip Code			10g. Citizen of			
i	1509 Greendale	Road			21218			United			
	11. Merital Stetus	12. Wes Dec Armed F	edent Ever in U prces?	J,S. 13. 1	Was Decedent of I If Yes, specify Cub	Hispenic Origin?	(Specify Yes or No arto Rican, etc.))- 14. Re Ble	ce - Ameri ck, White,	ican Indian, , etc.	
2	1 Never Married 2 Marrie	d 1 Yes				1 Yes 2 No Specify:			ly: W	hite	
	3 Widowed 4 Divorced	Year or E	Dates:								
200	15. Decadent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occu kind of work done	during most of w	rorking	16b. Kind of E	Business/Ir	idustry	
Completed	Elementery/Secondary (0-12)	College (Teach	DO NOT use retire	ii e uj		City Scho		1-	
	17. Father's Name (First, Middle, L	2	•	Teaci	ier	10 Mathada N	eme (First, Middle			18	
ne	John Bernard Hi					D10		-			
0				401 00 00		Mary E		Lecate		- 0-4-1	
	19a. Informant's Name/Relationsh Richard Bader/I		Don				Rurel Route Numb			b Code)	
		ersonar			Bethel sition (Neme of	road fi	nksburg,		.048	Saum State	
	20a. Method of Disposition 1 Darriel 2 Dcremetion	B □Removal from	State	cemetery, crer	netory or other ple		Dete	20c. Location			
	4 □ Donation 5 X Other (Sp.	ecity) entaribi	ent Lo	oudon P	ark Ceme	tery	7/9/98	Baltin	ore,	Maryland	
	23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that only one ceuse on	caused the dee	6	500 York	Road F	d Home, Baltimore	. Marvl	and	21212 Approximete Interval Between Onset and Death	
177.1	resulting in deeth)	θ	Due to (or es a consec	quence of).						
Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	Ь	Due to (or as e consec	quenca of):						
edicai	Inat initiated events	C	C. Due to (or as e consequence of):								
3	resulting in death) Last		220101								
M C		d									
Physician/	Part II. Other significant condition	s contributing to d	leath but not re-	sulting In the u	ndedvina cause a	iven in Part i	23h Did	tobacco use c	ontribute	to the cause of death	
lly a		o continuenting to c		January III and a	indonying dadde g			Yes 2 No	3 □ Pro		
							-	N			
								en eutopsy ormed?	a o	Vere autopsy findings vsileble prior to ompletion of cause	
-							A		0	f death?	
combiered							19	Yes 2□ No	1	Yes 2□ No	
3	25. Was case referred to medical exeminer?	Hospital			-		eeth (Check only	one)			
	XIX Yes 2 No			ER/Outpatier	NI JLI DOA	her: 4 Nursing			ther (Spec	ity)	
5	27. Manner of Death 1 □Naturel 5 □ Pending		of Injury oth, Dey Year)	28b. Time of Injury	Wo		280. Describe	how injury occu	Deni	sto a-	
Certification:	3 Suicide 6 Could n	ot be	K	102		Yes 2 No	04910	4041	dour	701905	
Ę	4 Homicide determin	AND ZOU. PING	a of Injury - At h ling, etc. (Speci	iome, farm, str	reet, factory, office		28f. Location City or To	(Street end Nun	Der or Hui	A Noute Namber,	
S	Carlo de Carlo		A	7 th	me		13070	reendo	He 1	FU.	
edicai	Modical E	Physician: To the xaminer: On the b	best of my knows basis of examination	owledge, death etion end/or in	h occurred at the t vestigation, in my	ime, dete end ple opinion, death oc	ca, and due to the curred et the time,	ceuse(s) and not date and place	nenner as	stated. to the ceuse(s)	
Vec	- A	end mer									
2	29b. Signature and title of certifier	/ 4			∠9C. LICen	se number		29d. Date sign	ea (Moulu	, Day, rear)	

OCME

CFFNO111 Penn Street, Baltimore, Maryland 21201

who completed cause of deeth (Item 23e) (Type, Print)

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

TIE	DA/A	TNF.	
110	RIVIA	IIVr.	

JORDAN **Physician** /Medical

1. Decedent's Name (First, Middle, Last) Jermaine J.

Jordan

2. Date of Death

05, 1998

3. Time of Death

Examiner

JULY 4b. City, Town, or Location of Death 6:44P.M.

Birthplece (State or Foreign Country)

10d. Inside City Limits

MD

Funeral Director

with the Marylend r 28a-f show Directo Examiner must be r deeth y Funeral filed within 72 hours after "naturel", or þ Completed the Medical and Mental Hygiena.

4a Facility Name (If not institution, give street and number)

BALTIMORE

4c. County of Death

JOHNS HOPKINS HOSPITAL 5. Social Security Number

7. Age (In yrs. last birthday) 1 X 2 F Yrs. 15

If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Days Hours

213-04-0417 Usual Residence of Decedent 10a. State 10b. County

NA

10c. City, Town or Location Baltimore

1 Xes 2 No

10e. Street and Number

MD

1612 E. Oliver Street

10f. Zip Code 21213 10g. Citizen of What Country? USA

06-04-83

11. Maritai Status

1 X Never Married 2 ☐ Married 3 Widowed 4 Divorced

12. Was Decedent Evar in U,S. Armad Forcas? 1 ☐ Yas 2X No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 1 ☐ Yes Z☐No Specify:

14. Race - American Indian. Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 10th Grade

Student

Student

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middla, Maiden Sumame) Monica Morton

Darian

19e. Informent's Name/Relationship (Type, Print)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

Darian

Jordan 20a. Method of Disposition Burial 2 Cramation 3 Removal from State

Jordan

20b. Place of Disposition (Neme of cemetery, crematory or other place)

5A-Robinson Court Fort Benning, GA 20c. Location - City or Town, State Md.

Baltimore, Maryland 21202

4 Donation 5 Other (Specify)

Garrison Forest VA Cem. 07-13-98 Owings Mills 22. Name and Address of Facility

21. Signature of Funeral Service Licenses

WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Daath

Physician

permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oths eny Injury or other traumatic event, once.

2

/Medical Examiner physician end s the buriel-transit The law requires that the death certificate be axecuted

88 USB B

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certificate has

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Physician:

of Vital Records,

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Bivisi

Examiner

Physician/Medical

by

Completed

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10

Certification:

Medical

Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Diseese or injury that initieted events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Immediate Cause (Final disease or condition resulting in death)

Due to (or es a consequence of)

Due to (or es e consequence of) Due to (or as a consequence of)

23b. Did tobacco usa contribute to the cause of death?

1 Yes

3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of ceusa of death?

or Rural Route Number,

25. Wes case referred to medice axaminar? 1 Yas 2 No

5 Pending investigation

6 Could not be determined

Hospitel:

1 ☐ Inpatiant 2 ☑ ER/Outpatiant 3 ☐ DOA 28a. Dete of Injury 28b. Time of Injury 98 1870

Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 | Yes

Other: 4 Nursing Home 5 Reaidence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number City or Town, State)

26. Place of Death (Check only one)

27. Manner of Deeth

1 Natural

2 Accident

3 Sujcide

4 Comicide

STREET Dollas 1600 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place; and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Sig

29c. Licensa number

29d. Data signed (Month, Day, Year)

O.C.M.E.

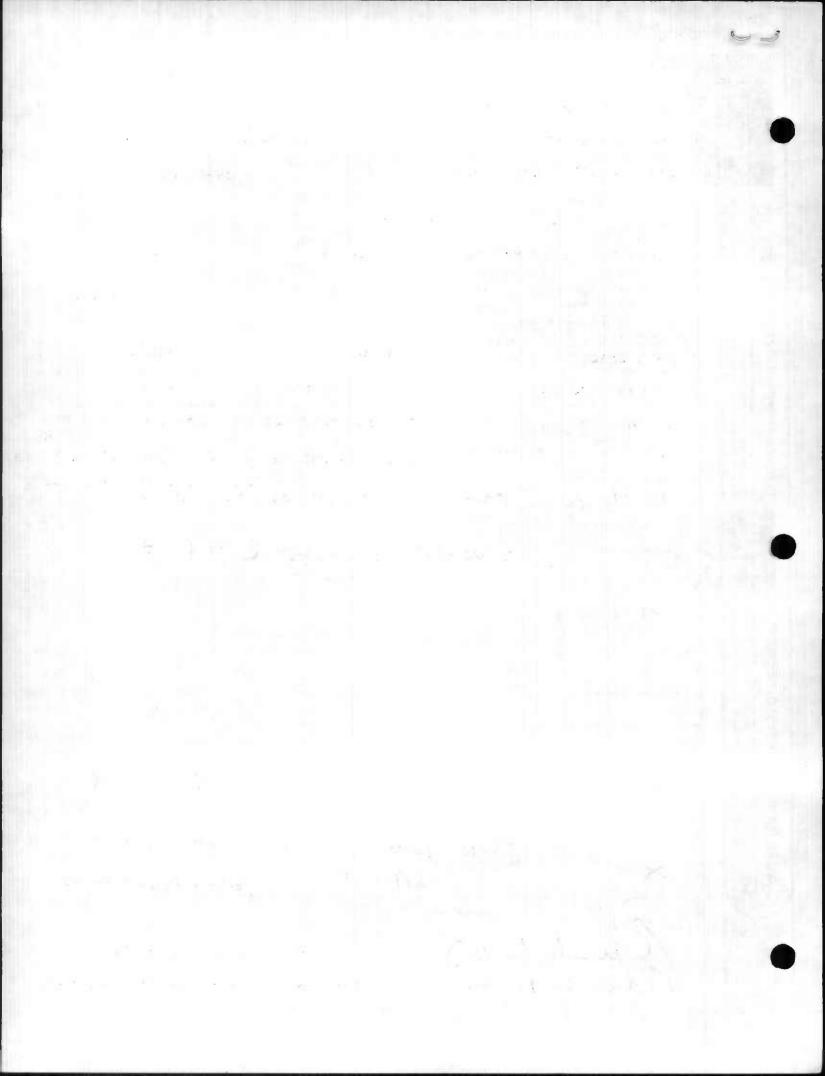
JULY 6,1998

and address of person who completed cause of death (Item 23a) (Type, Print) WCKE

111 Penn Street, Baltimore, Maryland 21201

Registrar's Signature a Daydoon

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death - 36 JOHN **Physician** 01 1998 /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** B AHIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) BA/timase MANOR Kuxton. 6. Sex 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1 M 28 F Months Devs 214-26-5416 76 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits Director 1 XYes 2 No Md N/A BALTO 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 4430 WRENWOOD AVE 2 1 2 1 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indien 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK by 3X Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) UNIT CLERK 18. Mother's Name (First, Middle, Meiden Surneme) HOSPITAL 12th 2 yrs 17. Fether's Neme (First, Middle, Last) Be 2 HARVEY ROSE MAGGIE PRESTON 19a. Informant's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) MARGARET ROWE 974 E. LOCUST AVE PHILADELPHIA, PA 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State NATIONAL MEM PK 7-8-98 LAUREL, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature de Fuperal Service Licensee BETTS FUNERAL HOME 22. Name end Address of Facility 1129 N. CAROLINE ST BALTO, MD 21213 23a. Part Ethér the disease for complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, inc., or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death fmmediete Cause (Final disease or condition resulting in death) 11ROSEPSIS mo DEC UBITUS ULCERS Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initieted events resulting in death) Lest Physician/Medical Due to (or es e consequence of): Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings evallable prior to completion of cause of deeth? DEMENTIA 24e. Wes en eutopsy performed? 1 TYes 2 No 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred

1 Tes 2 No

00051228

Market and place, and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

Madical Examinar: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

MD 2128

29d Date Joned (Moon, Dey, Year)

07/06/98

Records, P.O. Box 68760, Division of Vital Aftar

Funeral

Director

28a-f show

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'natural', or items 23a

Hygiana.

permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: If Item 27 is marked other any lijury or other traumatic event 2008.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

or Attending Physician: 24 hours after death. 2 fillad in Hospital within 24 ho To the Fune completely f

Registrar

edicai

WEST 31. Date filed (Month, Day, Yeer) State JUL 0 9 1998

Naturel

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and at

5 Pending

investigetion

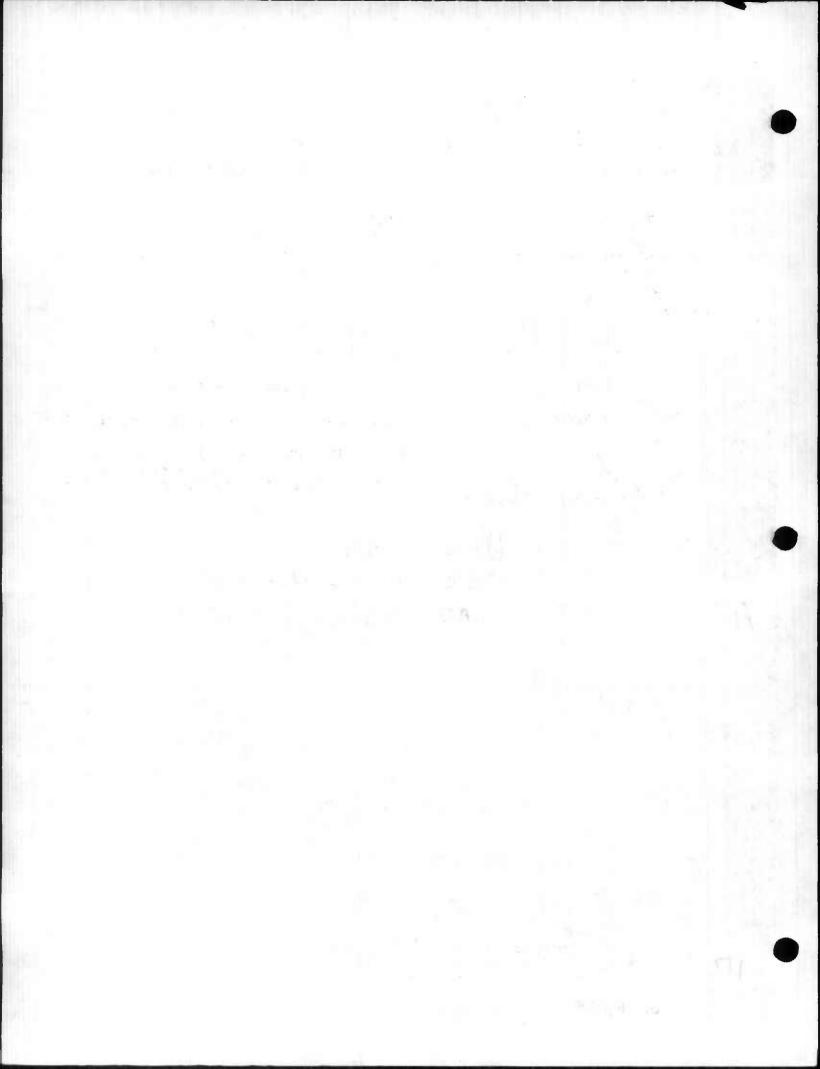
6 Could not be determined

RAMANAGOPALAN MD

30. Name end address of person who completed cause of deeth (item 23e) (Type, Print)

ROLLING CROSSIZOADS 32. Registrar's Signature

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** William Lewis 1998 July /Medicai 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Baltimore 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) **Funeral** Months Hours 1 🖾 M 2 🗆 F Days Yrs. Director 226-18-7572 84 Feb. 26, 1914 NC Usual Residence of Decedent the Marylan 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1⊠ Yas 2□No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1118 N. Milton Ave. 21213 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Maritel Status 14. Rece - American Indien, Black. White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Black À 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5th Construction Knox Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumeme) 0 Unknown Ella Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) epartment of Health an Important: it hem 27 is a Deborah Allen-Edem 4018 Balfern Ave., Baltimore, MD 21213 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date Pages nent of P 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Zion Cemetery 07/11/98 Lansdowne, MD 21. Signature of Funerel Service Licenses 22. Name and Address of Facility Unity Funeral Home - 108 W. North Ave. 21201 - (410) 752-4941 Baltimore, MD Part. Enter the disease, or complications that caused the shall be not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medicai Immediate Causa (Final disease or conditi-rasulting in death) Examiner Examiner PM5100 Sequentially list conditions, if any, laading to Immediata causa. Entar Underlying Cause (Disaase or Injury that initiated evants resulting in death) Last Physician/Medicai Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown be det by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of daath? Completed page 2 1 Yes 2 No certifica director. Be 25. Was cese rafarred to medical 26. Placa of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3(290A this 28a. Data of Injury (Month, Dey Year) 27. Mangar of Deeth 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 2 Accidant 5 Panding

Division of Vital Records, P.O. Box Hospital or Attending Physician: 24 hours after deeth. funeral After Director: A

within 24 hours a
To the Funeral E
completely filled To the

31. Date filed (Month, Dey, Yeer) State Registrar

we

29c. License number

1 ☐ Yes 2 ☐ No

Certifying Phyaician: To tha best of my knowledga, daath occurred at tha time, date and place, and dua to tha causa(s) and manner as stated.

2 Medical Examiner: On tha basis of examination and/or investigation, in my opinion, daath occurred at the tima, date and place, and due to the cause(s) and manner statad. 29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Steta)

of daath (Itam 23a) (Type, Print)

Investigation

6 Could not be datarmined

3 ☐ Suicide

29a. Certifier

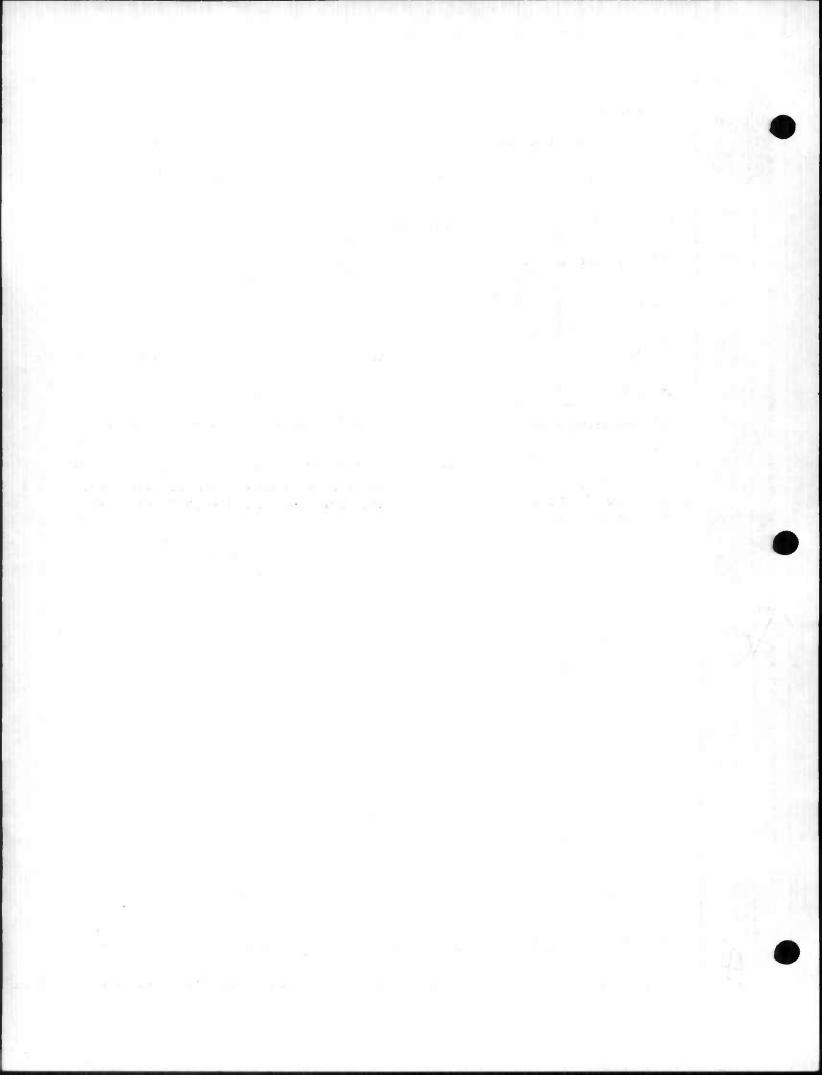
4 Homicida

29b. Signeture and title of certifie

JUL 0 9 1998

28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)

32. Ragistrar's Signature



98-3842-031

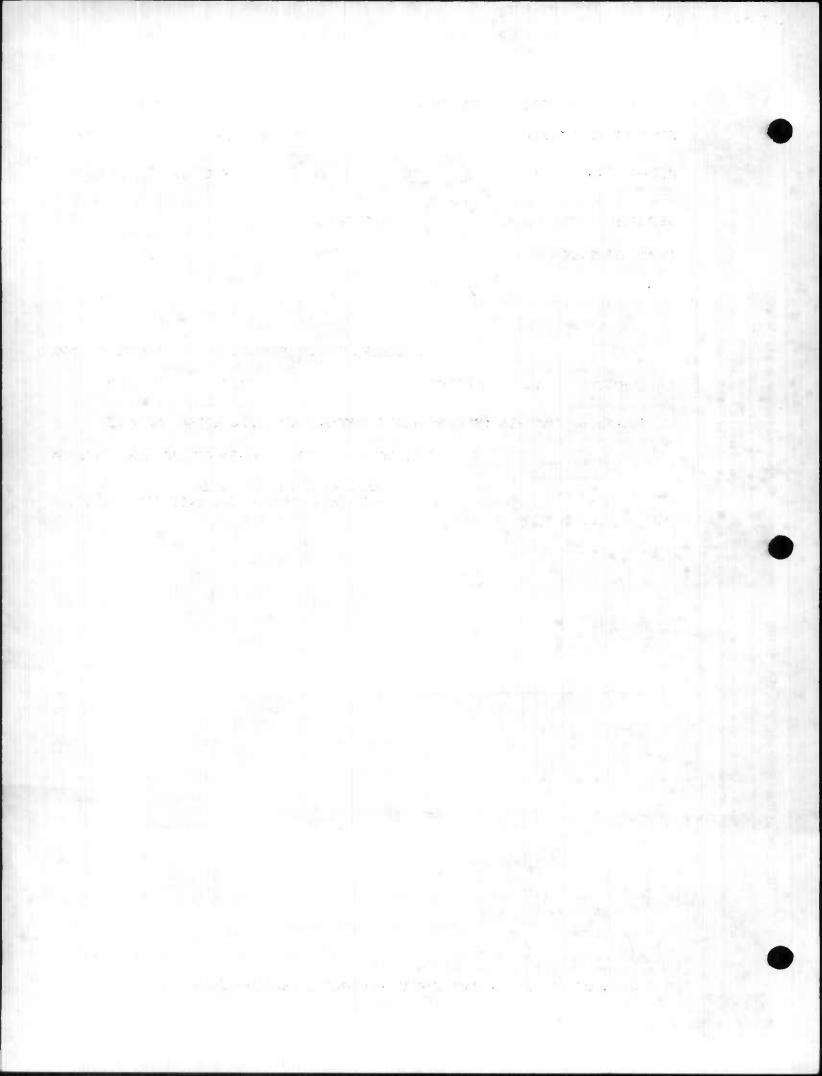
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Manuford / Department of Health and Mantal Hydiana

State of Maryland / Department of Health and Mental Hygiene Amended #23a,27,28a,b,c,d,e,f,perMEOG761 7/14/98 Dertificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** JULY 4, T.998 ART **JONATHAN** MITCHELL 5:46PM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SHADY GROVE HOSPITAL GAITHERSBURG MONTGOMERY If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 10M 20F Months Deys Hours Min 422-92-3719 38rs. AUG. 23,1959 ALABAMA **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 √Yes 2 No Directo MARYLAND MONTGOMERY POOLESVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23s or actical Examiner must be r 19808 WESTERLY AVE. 20837 USA Funeral filed within 72 hours after deeth 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ≥ ☐ No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☑ Divorced Completed the Medical 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) CUSTOMER SERVICE REPRESENTATIVE PRINTING COMPANY 7 is marked othe treumatic event, 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) of Heelth end Mental H item 27 is marked oth Be RAUNEY MITCHELL WANDA JACKSON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MR. RAUNEY L. MITCHELL (FATHER) 19808 WESTERLY AVE POOLESVILLE, MD 20837 other Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other p. 20a. Method of Disposition 20c. Location - City or Town, Stete Pages 1 nent of H int: If ite 1 Buriei 2 Cremetion 3 Removel from State 7+9-98 COLBERT CO., ALABAMA Department Inportant: If PINEÝ GROVE CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) Injury 22. Name end Address of Fecility
SOL LEVINSON & BROS., INC. 21. Signeture of Funerel Service Licensee 8900 REISTERSTOWN ROAD BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical tmmedlete Ceuse (Finel ACUTE NARCOTIC and ETHANOL INTOXICATION disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examine attanding physicien end for use as the bunal-transit certificate be assecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): signed by the a 23b. Did tobacco was contribute to the cause of death? Pert II. Other elanificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yaa 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings aveilable prior to 24a. Wes en autopsy Completed completion of ceuse of death? page 2 s 1X Yes 2 No 1 XYas 2 No certificate Division of Vital or Attending Physician: funeral director Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 🕅 🔭 PI/Outpetient 3 ☐ DOA ¥XYes 2□ No P this 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? After 5 Pending investigation 1 Neturel after death. 1 ☐ Yes 2 ☑ No Found 7-4-98 Found 5;20pm Unknown 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete). filled in by 4 Homicide Unknown 24 hours e Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical completaly (Check only one) within 2 To the I 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifier 0 herte no JULY 05, 1998 unn O.C.M.E. 30. Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print) DENNIS J. CHUTE, MD 111 PENN STREET BALTIMORE, Maryland 21201 32. Registary Signature Randage 31. Dete filed (Month, Dey, Year) State 141998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death **Physician** July 06, 1998 05:25PM /Medical 4a. Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner VA Maryland Health Care System Perry Point Cecil If Undar 1 Yaar 5. Social Sacurity Number 6. Sax Aga (In yrs. last birthday) Birthpleca (Stata or Foraign **Funeral** Months Days Hours 212-48-257 Usual Residence of Dacadant 1 M 2 □ F Yrs. Director and 10b. County 10a. Stata 10d. Insida City Limits 28a-1 show Examiner must be notified at Randal 1 XYas 2 No Baltimore Directo Varyland TOWY 10e. Street and Numbar 10f. Zip Code 10g. Citizan of What Country? 5 SV 0 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Race - Amarlcan Indian, Black, Whita, atc. 1 KAYas 2 □ No If Yas, Giva Yaar or Datas: 1 □ Navar Married 2 □ Married 1 ☐ Yas 2 No Specify by 3XWidowed 4 ☐ Divorced ifrican Hmerican Completed traumatic event, the Medical 15. Decedent's Education (Specify only highast grada complated) 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) College (1-4or 5+) 15able 0 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sume Be XON a 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or (niece) City or Town, Stete, Zip Coda) Demn. Oatmant of Hears. Important: If Item 27 is 2848 Balto, Md. 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata Data 1 Burlal 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) ores of Funeral Service Libensaa Joseph L. Kuss 2222 W. North 2/2/6 less, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory. List only one ceuse on each line. Approximata Interval Batween Onsat and Death **Physician** Immediata Ceusa (Final disaasa or condition rasulting in death) /Medical a End stage liver cirrhosis unknown Examiner Dua to (or as a consequence of): Examiner Hepatitis C unknown Sequantially list conditions, if eny, laeding to immediate causa. Entar Undarlying Causa (Disaase or injury that Initiated evants rasulting In daath) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed page 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Pleca of Deeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 XNo 1 XInpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Mepper of Death 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accidant

that the death certificeta be axecuted P.O. Box 68760, attending for use as 2 signed b vision of Vital Records, peeu certificata Attending Physician: this funaral Affer

MIXON, ALTHERON

NAME KNOWN TO PHYSIGIAN: Baltimore, Maryland 21213-5620:

filed within 7 Hygiene.

Pages 1 end 2 should be nant of Health end Mental

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 1 Cartifying Physician: To the best of my knowledga, daath occurred at tha tima, date and place, end due to the ceuse(s) end menner es steted.
2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) and manner stated. 29e. Cartifiar 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year)

D42682

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

July 06, 1998

30. Nema and address of person who complated cause of death (Item 23e) (Type, Print)

6 Could not ba

JASWINDER SODHI, M.D., VA Maryland Health Care System, Perry Point, MD 21902

State Registrar

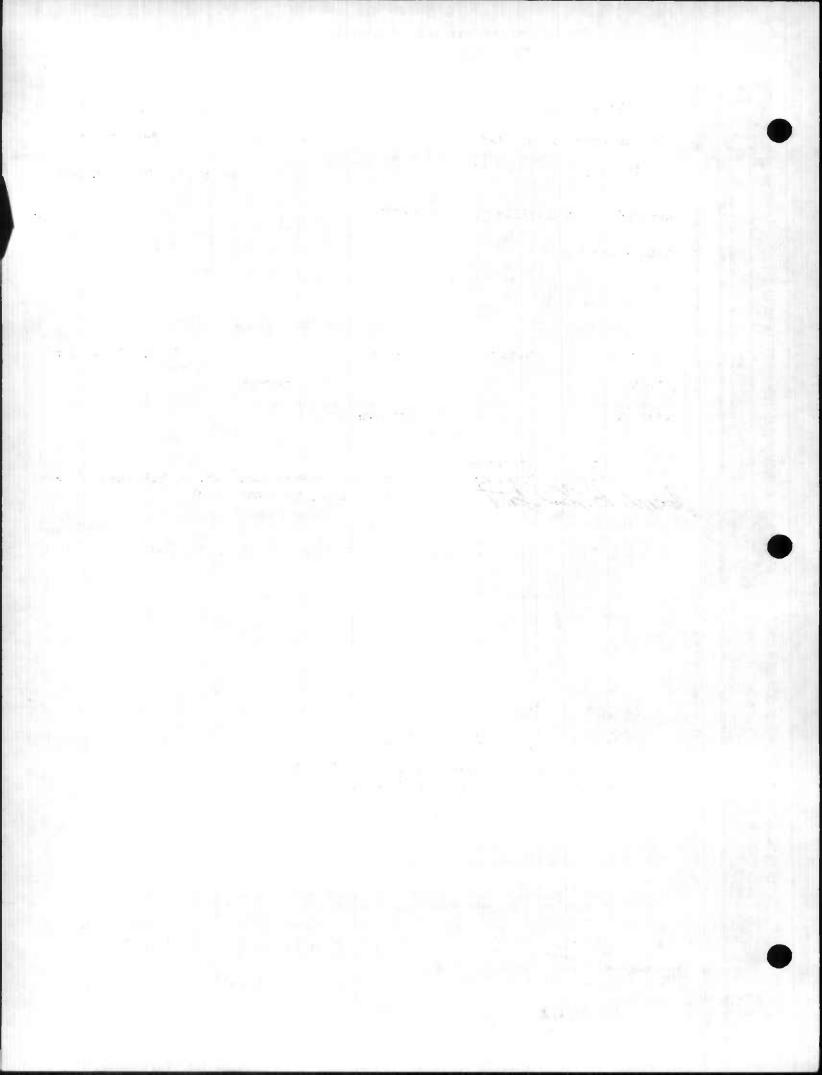
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State of Maryland / Department of Health and Mental Hygiene

Table Tabl	tsville 9. Birthplace (State or Foreig Country) Germany 10d. Inside City Limits 1□ Yes 2\square Note that Country? - American Indian, , White, etc. White Iness/Industry f Maryland		
Rividad Reminder A Facility Name (in administration, give street and number) Prince Georges Hospital Social Security Number B. Sext Social Sec	f Death tsville 9. Birthplace (State or Foreig Country) Germany 10d. Inside City Limite 1□ Yes 2\notenant Notenate Country? - American Indian, White, etc. White Iness/Industry f Maryland		
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No. State 100. County Hyattsville 100. City, Town or Location 100. City Code 100. Citizen ct Will U.S. A. 100.	1 □ Yes 2 ☒ Note that Country? - American Indian, , White, etc. White Iness/Industry f Maryland		
Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or es e consequence of):	- American Indian, , White, etc. White Iness/Industry f Maryland		
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Physician / Medical Examiner Physician / Medical Examiner Sequentially list conditions, if any, leading to immediate double that initiated events in the limited events are sufficient conditions, as a consequence of limited to the particular of	itate, Zip Code)		
Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Physician //Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or es e consequence of):			
Physician //Medical Examiner Sequentially list conditions, if any, leading to immediate disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): A per lii, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No Pert II, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 24a. Was an autopsy performed?	City or Town, State		
Physician /Medical Examiner Medical Examiner Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due	more Street		
Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 24a. Was an autopsy performed? Charie Veul: Defreudaut	\$R.\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
24a. Was an autopsy performed? Change veul. Defreudaut.	d tobacco use contribute to the cause of death		
Chronie vent Dependant	24b. Were autopsy tindings available prior to completion of cause		
Commany Aten Miseage	ot deeth?		
25. Was case reterred to medical examiner? 1 Yes 2 Hospital: 1 inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other	r (Snecity)		
27. Manne of Death 28a. Date of injury 1 Naturel 5 Pending (Month, Day Year) 28b. Time of injury 4 Nork? 1 Yes 2 No	1-1		
1 Yes 2	r or Rural Route Number,		
1 Yes 2 Mo 1 Yes 2 Mo 25. Was case reterred to medical examiner? 1 Yes 2 Mo Month, Day Year 28b. Time of injury et work? 1 Yes 2 Mo North 28d. Describe how injury occurred work? 1 Yes 2 Mo North 28d. Describe how injury occurred work? 1 Yes 2 Mo North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 No North 28d. Describe how injury occurred work? 1 Yes 2 North 28d. Describe how injury occurred work? 1 Yes 2 North 28d. Describe how injury occurred work? 1 Yes 2 North 28d. Describe how	ner aa stated. nd due to the cause(s)		
29b. Signaturn and title of cartifler 29c. License number D 48213 6-13	(Month, Day, Year)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. ASNOW YOU MITCHEM TO A 230 BOWNE HD 2	L-18		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) 5-30 AM JULY Mueller Katherine Marie 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) 4c. County of Deeth Glen Burnie North Arundel Anne Arundel Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthplace (Stata or Foreign Country) Sex 1□M 2ØF .Months Yrs. 86 212-09-7021 Dec. 7, 1911 Maryland Usuat Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2068 Kurtz Ave. 21122 USA 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 (M)o If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Maritat Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Etementery/Secondary (0-12) College (1-4or 5+) Homemaker Household 18. Mother's Name (First, Middle, Malden Sumeme) 17. Fathar's Nama (First, Middla, Last)

Martha

19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code)

Kopps

permit. Pages and 2 Department of Health a Important: If item 271s any injury or other true **Physician** /Medical Examiner

Physician

^{*} /Medical

Examiner

10a State

Rudo1ph

19a. Informant's Name/Relationship (Type, Print)

Director

Funeral

Aq.

Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show treumetic event, the Medical Example: must be notified at

al Hygiena. 2 should be filed within and Mental Hydiens.

atremi

poe attending physician for use as the buria Box 68760. Records, P.O. signed by ti has Division of Vital funeral director, death. or Attenda after death Director:

To the Hospital o within 24 hours af To the Funeral Di completely filled is

Physician/Medical 20 Completed Be To Certification:

27. Menner of Death

1 Natural

2 Accident

3 Suicida

29a. Certifier (Check only one)

4 ☐ Homicide

Ayoku 31. Date filed (Month, Dey, Year)

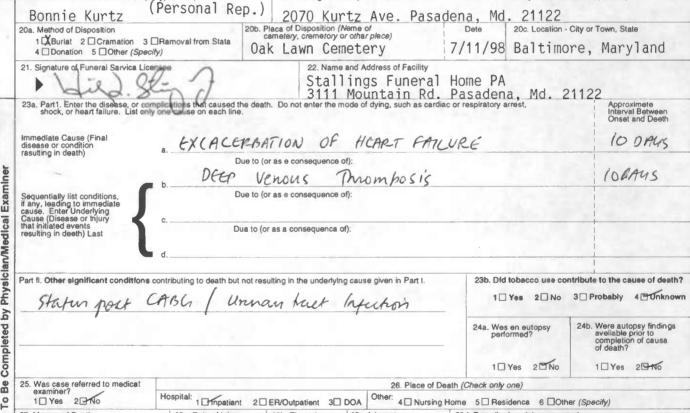
29b. Signatura and title of cartifier

5 Pending Investigation

6 Could not be determined

) ketunii

State Registrar



28c. fnjury at Work?

1 Certifying Physicfen: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) and mannar stated.

29c. License number

1 ☐ Yes 2 ☐ No

BC 5572195

28d. Describe how tnjury occurred

Glen Burnte, Md. 2106

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date stgned (Month, Dey, Year)

TULY 8, 1998

Schnitzker

32. Registrar's Signatura Julia Tairdson Randoll

28a. Date of Injury (Month, Day Year)

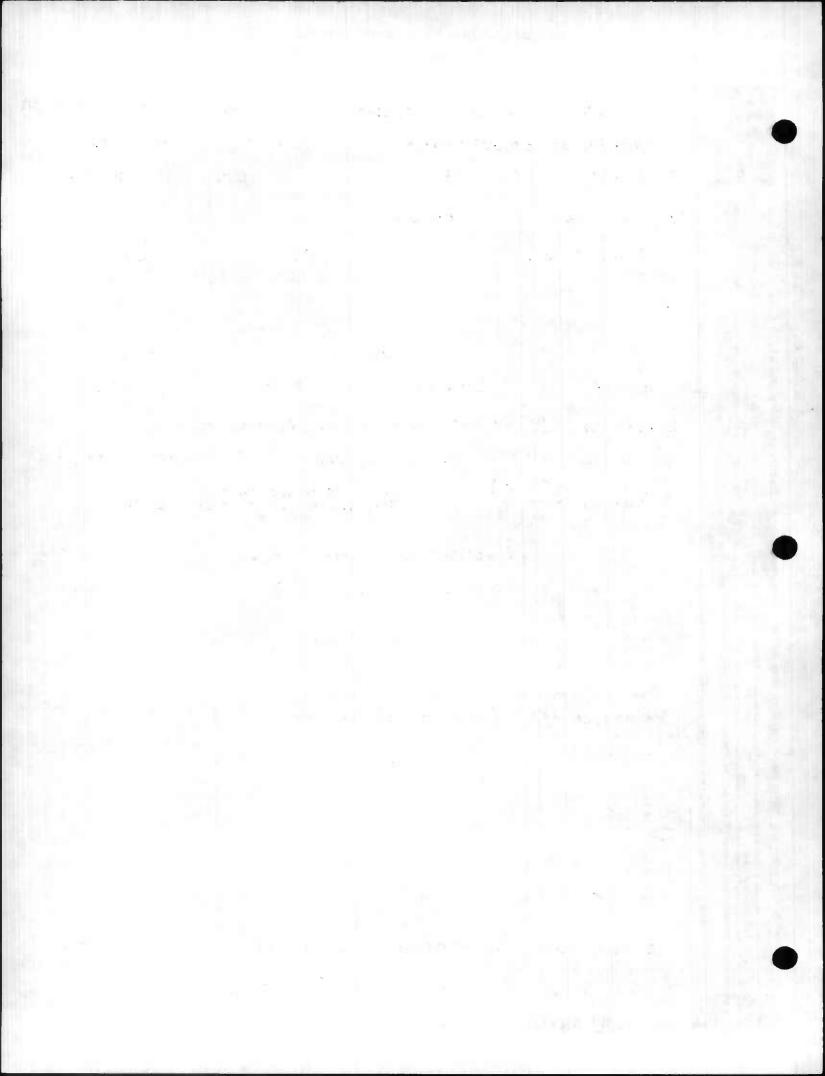
holiack House STATE MEDICINE

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 1: MD 301

28b. Time of

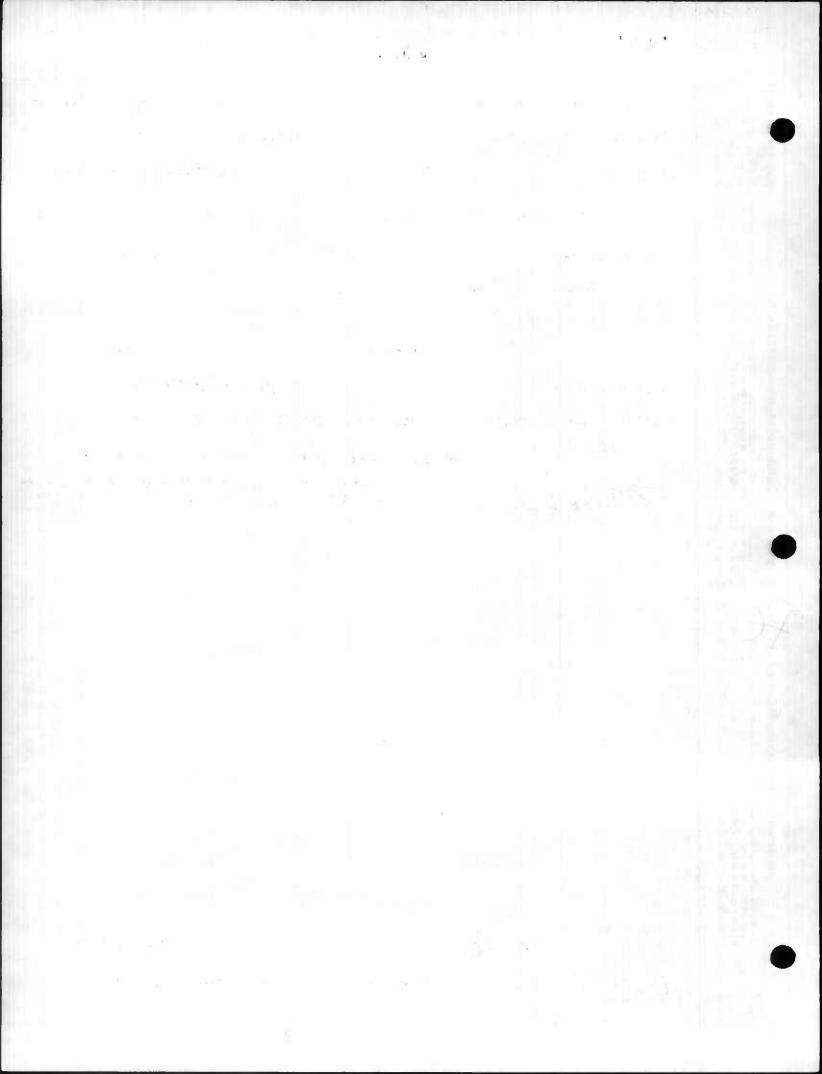
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Hospital



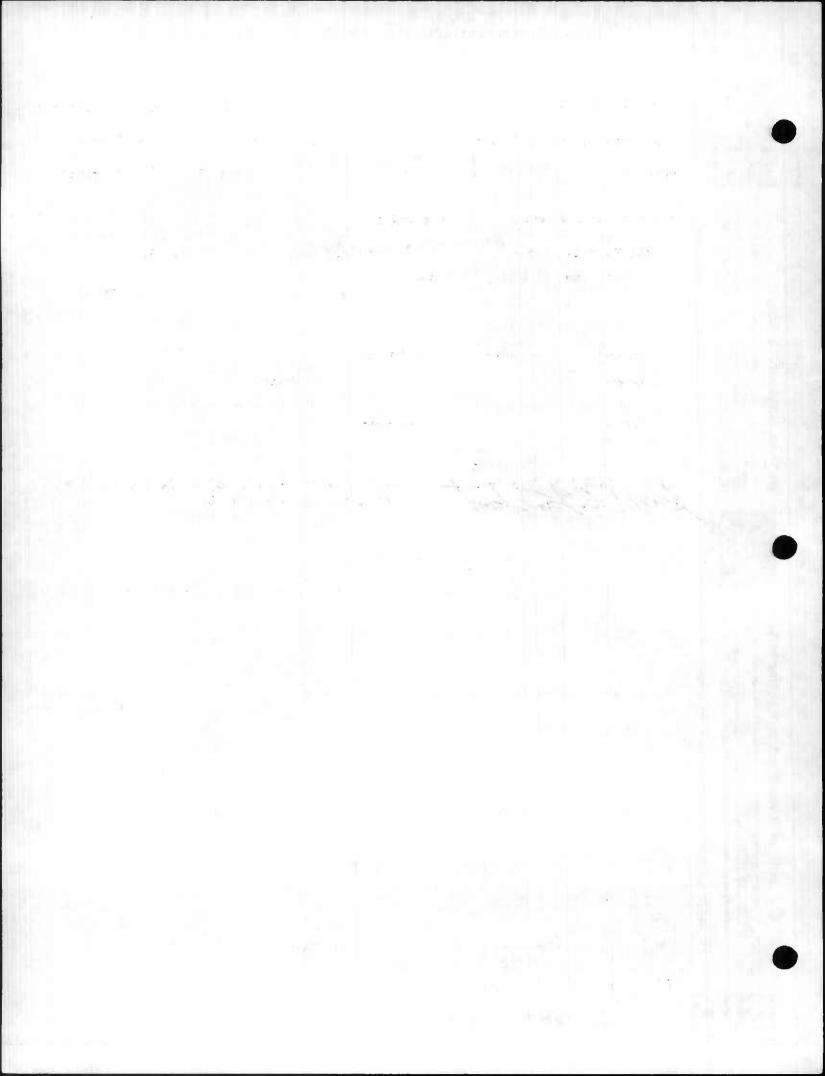
State of Maryland / Department of Health and Mental Hygiene

Physician	PART I, 27 PER MEO G76: 1. Decedent's Neme (First, Middle, L	ast)				7 7	2. Dete of De Month	Dev	Year (Time of Death
/Medical	Georgia Ann	Neugent	-			A: 7	JUNE	18, 199	8)200 AM
Examiner	4a Facility Name (If not institution, gas BAYVIEW EMERGEN				40	BALT'IM	Location of Deat ORE	h 4c. County	A	
Funeral Director	5. Social Security Number 6. 215–32–3343 Usual Residence of Decedant	Sex Y 7. Age (In yrs. last birthd	Montha	Days	If Under 24 Hr Hours Mir		o, 1935	9. Birthplace Country) Mary1	(Stata or Foreign and
r show sdat	10a. State 10b. County MD Balt:		0c. City, Town o	r Location						nalde City Limits Yes 211 No
rect	10e. Street and Number				p Code			10g. Citizen of V	What Country?	
at pe	2605 Snyder Aver	nue			21219			U.S	.A.	
Department of Haalth and Mental Hygiana. Important: If Itam 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Modeal Examiner must be notified at once. To Be Completed by Funeral Director	11. Maritel Status 1 Never Married Married 3 Widowed 4 Divorced	12, Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Detes:	er In U,S.	I3. Wes Dece If Yes, spo 1 \(\text{Yes}	37	panic Origin? (, Maxicen, Pue Specify:	Specify Yes or Norto Rican, etc.)	o- 14. Rac Blac Specify	a - American in ck, White, etc.	
ted bet	15. Decedent's I		16e. De	ecedent's Usi	ual Occupat	ion	ndring	16b. Kind of Bu	usiness/Industr	/
ygiana. Ner than "neture of, the Medical. Completed	(Specify only highest g	College (1-4or 5+)				iring most of w	// King	0 11		
Hygiana. ort, the	12	ad .	Но	memake		4D. Mathada Mi	ma /First Middle	Own H		
ed out	17. Father's Name (First, Middle, Las William L. Jones							, Ma <i>iden Suman</i> orthsyth		
umatic To	19a. Informant's Name/Relationship		19b. M	lailing Addras	s (Street a			per, City or Town,		(e)
n 27 is ma	William R. Neuge						emere, M			
nent of Haalth int: If Itam 27 iry or other ti	20a. Method of Disposition 1 Burial 2 Seremation 3 4 Donation 5 Other (Spec		20b. Place of D. cemetery, Baltimo	crematory or	othar place		Date 6/22/9		City or Town,	
Depertment of the control of the con	21. Signature of Funeral Service Lice	I A Noi	107					-Matthew Baltimor		al Home 21222
s the buriel-transit	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	Du Du	OBSTRUCTION Use to (or as a consistence to (or a consistence t	nsequence of):	ISEASE				
0 6 -		d								
sic sic	Part II. Other significant conditions	contributing to death but	not rasulting in th	e underlying	cause give	n in Part I.	23b. Dld	tobacco uss co	ntributa to the	causs of death?
===							1	Yas 2□No	3 Probably	y 4⊠'Unknowi
ed by the datach							24a. Wa	s an autopsy ormed?	avallab	utopsy findings le prior to tion of cause h?
s been signed by the attending g 2 should be datached for use as pleted by Physician/Me					-					
8 Cl CT					-		19	Yas 2□No	142 Ye	8 2 No
8 Cl CT	25. Was case referred to medical				-	26. Place of D	1 Path (Check only		14 /2 1 Ye	8 2 No
8 Cl CT	25. Was case referred to medical examiner? 1 ☑ ★es 2 ☐ No	Hospital: 1 Inpatient				r: 4□ Nursing	eath (Check only Homa 5 Ras	ona) idanca 6 □Oth	ner (Specify)	8 2□ No
8 Cl CT	25. Was case referred to medical examiner? 1 2 ses 2 No 27. Mannar of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	28b. Tim	ie of	28c. Injury Work	r: 4□ Nursing at ?	eath (Check only Homa 5 Ras	ona)	ner (Specify)	© 2□No
deeth. stor: Aftar this certificate hes y tha funaral director, page 2 floation: To Be Comp	25. Was case referred to medical examiner? 1 ☑ ¥es 2 ☐ No 27. Mannar of Death	28a. Date of Injury (Month, Day)	28b. Tim Inju	ne of ary M	28c. Injury Work 1 🗆 Y	r: 4□ Nursing	eath (Check only Homa 5 Ras 28d. Dascribe	ona) idanca 6 □Oth	ner (Specify)	
deeth. stor: Aftar this certificate hes y tha funaral director, page 2 floation: To Be Comp	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day)	28b. Tim Inju - At home, farm (Specify) ny knowledga, d kaminetion and/o	M M , street, factor	28c. Injury Work 1 T	r: 4 ☐ Nursing at ? es 2 ☐ No	eath (Check only) Homa 5 Ras 28d. Dascribe 28l. Location City or To	ona) idanca 6 Oth how Injury occur (Streat and Numb	ner (Specify) rred ber or Rural Ro	ute Number,
deeth. stor: Aftar this certificate hes y tha funaral director, page 2 floation: To Be Comp	25. Was case referred to medical examiner? 1 2 5 2 No 27. Mannar of Death 1 Natural 5 Pending investigati 3 Suicide 6 Could not detarmine 29a. Cartifiar Check only 2 Madical Examine	28a. Date of Injury (Month, Day) 28a. Place of Injury building, atc. (Physician: To tha best of raminar: On the basis of e)	28b. Tim Inju - At home, farm (Specify) ny knowledga, d kaminetion and/o	M M , street, factor leath occurred investigation	28c. Injury Work 1 T	at ? es 2 No	eath (Check only) Homa 5 Ras 28d. Dascribe 28l. Location City or To	ona) idanca 6 Oth how Injury occur (Streat and Numb	ner (Specify) per or Aural Ao annar as stated and due to the	ute Number,
in 24 hours eftar deeth. Funeral Director: Aftar this certificate has plately filled in by tha funaral director, page 2 gelical Certification: To Be Comp	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day) 28a. Place of Injury building, atc. (Physician: To tha best of raminar: On the basis of e)	28b. Tim Inju - At home, farm (Specify) ny knowledga, d kaminetion and/o	M M , street, factor leath occurred investigation	28c. Injury Work 1 1 Y ory, office d at tha time n, in my op	at ? es 2 No a, data and placinion, deeth occurrence.	eath (Check only) Homa 5 Ras 28d. Dascribe 28l. Location City or To	ona) idanca 6 Oth how Injury occur (Streat and Numblewn, State) e causa(s) and min, date and placa, 29d. Dete signe	ner (Specify) per or Aural Ao annar as stated and due to the	ute Number, I. cause(s) Year)
deeth. stor: Aftar this certificate hes y tha funaral director, page 2 floation: To Be Comp	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day) 28a. Place of Injury building, atc. (Physician: To the best of raminer: On the basis of each manner state	'ear) 28b. Tim Injuing - At home, farm (Specify) my knowledga, d kaminetion and/od.	me of many M , street, factor leath occurred investigation 2: 2: 2: 2: 2: 2: 2: 2: 2: 2	28c. Injury Work 1 Vory, office d at tha tim.n, in my op 9c. License O.C.N	at ? es 2 No	eath (Check only Homa 5 Ras 28d. Dascribe 281. Location City or To	ona) idanca 6 Oth how Injury occur (Streat and Numblewn, State) e causa(s) and min, date and placa, 29d. Dete signe	ner (Specify) red ber or Rural Ro annar as stated and due to the od (Month, Day,	ute Number, I. cause(s) Year)

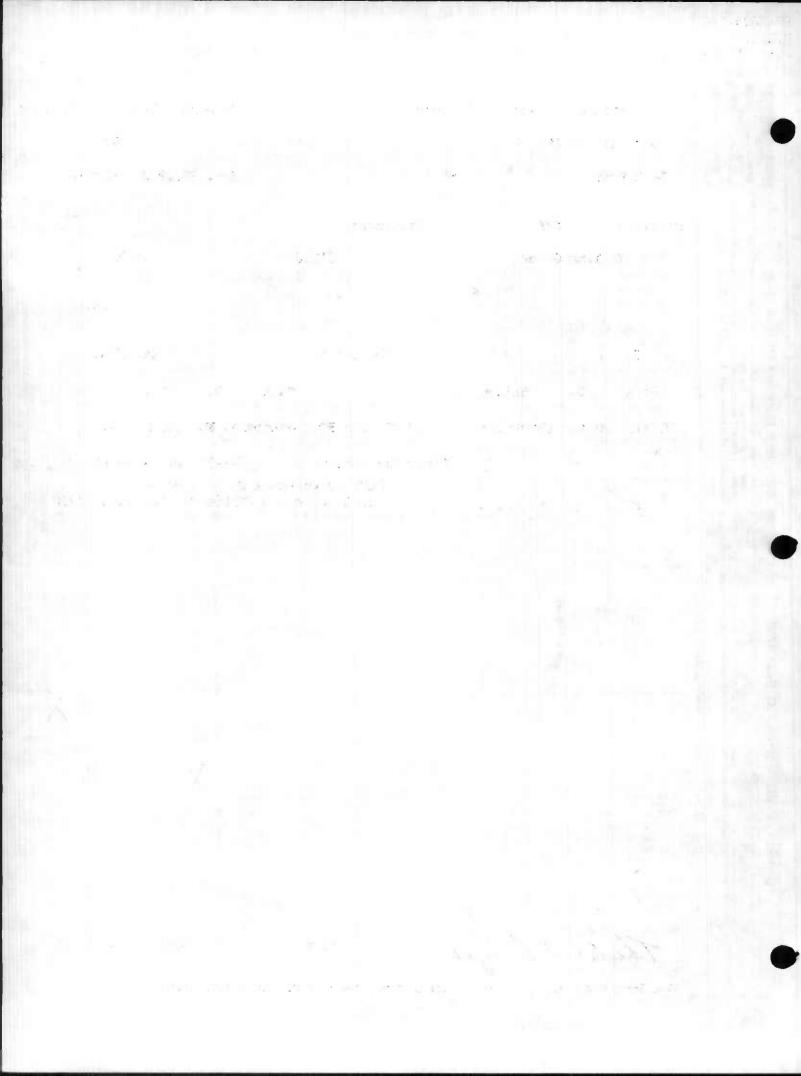


State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, L.	est)		Certifica	ate of i	Death	2. Date of Dec	Reg. No.	3. Time of Death	
Physician	Jared Patters						July 2		11:37 AM	
' /Medical Examiner	4s Facility Name (If not institution, g				- 1	tb. City, Town, or	Location of Death	Anna and an annual an annual and an annual		
LXammer	Anne Arundel Me	edical Cent	ter			Annapol	is	Anne	Arundel	
Funeral Director	unknown	ACTA ACTA	ge (In yes. last birth 58 Ye	Month	der 1 Year is Days	If Under 24 Hr Hours Min		, Year) 4, 1929	Birthplace (State or Foreign Country) Maryland	
B	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location					10d. Inside City Limits	
of all	Maryland Anne An	rundel	Edgew						1□Yes 2ŒNo	
be notified Director	10e. Street and Number	. unucz	Dagen		Zip Code			10g. Citizen of W	hat Country?	
	1731 Fairhill	or a formation and the second		2	21037			U.S.A.		
or, or its bramine by Fur	11. Marital Status unknown 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	No	1 ☐ Yes	2 %] No	Specify:	Specify Yes or No- rto Rican, etc.)	Specify:	- American Indian, c, White, etc. White	
Years, ver then "natural", it the Medical Exa	15. Decedent's (Specify only highest g	ducation rade completed)	16a. D	ecedent's Us	sual Occup work done	ation during most of we f)	orking	16b. Kind of Bu	siness/Industry	
mpl mpl	Elementary/Secondary (0-12)	College (1-for	5+)		use retired	1)		unknow		
	unknown	unknown	un	known		est death and blo	and Mint Mints	1000-000-000		
등 등	17. Father's Name (First, Middle, La: unknown	0				unknow	ame (First, Middle, 11.	Maiden Sumami	0)	
matic e	19a. Informant's Name/Relationship	(Time Date)	100. 4	Asilian Adda	ure /Owner	and Number or E	David Reada Maniba	ur Chu as Tana	State To Code	
or trau	unknown	(Type, Phil)				and realitions of a	NUMER PRODUCE PROFITOR	ral Route Number, City or Town, State, Zip Co		
1 4	20a. Method of Disposition		20b. Place of D	nknown	Vame of		Date	20c. Location -	City or Town, State	
ortant: If the injury or o	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	(y) in state	cemetery,	crematory o	r other plas	oe)				
important any injury spice.	21. Signature of Funeral Service Lio OSE DR 23a. Parti. Enter the disease, or co shock, or heart failure. List on	an Sam	/	Balti	more,	Maryla	nd 21201		more Street	
e as the burishment	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Char	Due to (or as a co	634v	othe di	PJ-	onary I	2)6-1-	•	
Hor use clan/h										
etached for use	Part II. Other significant conditions	contributing to death t	out not resulting in t	he underlyin	g cause giv	ven in Part I.	23b. Did	Did tobacco use contribute to the cause of death		
be delact							10	Yes 2 No	3 RProbably 4 □ Unknow	
2 should pleted								an autopsy cmed?	24b. Were autopsy findings available prior to completion of cause of death?	
Dage Com							101	res 200 No	1 ☐ Yes 2 ☐ No	
rector, page	25. Was case referred to medical examiner?					26. Place of D	eath (Check only o	ine)		
# 6	1 Yes 22 No	Hospital: 1 Minpati	ent 2 ER/Outp	etient 3	DOA OU	er: 4 Nursing	Home 5□ Resid	dence 8 DOthe	or (Specify)	
ther the	27. Manner of Death 1 MNetural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Inj. (Month, De		ne of ury M	28c. Injur Wor			ed		
To the Funeral Director: After completely filed in by the funer completely filed in by the funer Medical Certification:	3 ☐ Suicide 5 ☐ Could not distermine	208 11809 01 10	TO 12 (1990) 10 (1990)					Street and Number, State)	er or Aural Route Number,	
pletely fills edical (29a. Certifier 12 Certifying F	hyeicien: To the best miner: On the basis of and manner st	d examination and/	seath occurr or investigati	ed at the tir ion, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place, s	nner as stated. and due to the cause(s)	
Me Me	29b. Signature and title of certifier		NP (74)		29c, Licens	e number		29d. Date signed	(Month, Day, Year)	
- 0	1 Sul				D4-	7518		July ?	1998	
	30. Name and address of person wh	completed cause of	death (Item 23a) (T			,310		1	100 4	
	Theresa Bu	I M	4/10							
State	31. Date filed (Month, Day, Year)	32. Flegist	Tulia Davido	. 70.	00.					



tr	icia Roto	ndo , 28A-F PER MEO FILM G7	State of Maryland		artment of F		Mental Hy	rgiene 9	3 2	1041
		1. Decedent's Name (First, Middle, Last					2. Date of De	eath		3. Time of Death
	Physician	Patricia	Ann Roton	do			June	28, 1998	Year	10:06 AM
	/Medical Examiner	4a Fecility Name (If not institution, give				4b. City, Town,	or Location of Deel			10.00 111
	EASTINITE!	1524 William Str	reet			Baltim	ore		N/A	
	Funeral	Social Security Number 6. Se		ast birthdey)	Months Days			rth ev. Year)	9. Birthplac	ce (Stete or Foreign
Ь	Director	213-28-9440	□M 2 X F 65	Yrs.	INOTHITS Days	110013		29,1932		vland
	P .	Usual Residence of Decadent 10a. State 10b. County	10c City	, Town or L	ocation				10d	I. Inside City Limits
	sho ST									1⊠Yes 2□No
	the N	Maryland N/I	1	Balt:	imore 10f. Zip Code			10g. Citizen of V	Vhat Country	n
	eth with the Merylan 23a or 28a-1 show ant be notified a	1524 William Str	coot			.230		U.S		
	ifer deeth with the Me r tems 23s or 28s-1s offer mall be motilled Funeral Director	11. Marital Status	12. Was Decedent Ever in U,S	5. 13.	Was Decedent of I		(Specify Yes or N		e - American	
0	ther dee	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				erto Rican, etc.)		k, White, etc	0.
020	air, or items Example:	3 ☑ Widowed 4 ☐ Divorced	Il Yes, Give Year or Dates:		1□ Yes 2⊠ No	Specity:		Specify	Whi	ite
21215-0020	led within 72 hours after deeth with the Menyland tygiene. The Transfer was 28 or 284 show it, the Medical Exercitor was be notified at Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad		16a. Dece	edent's Usuei Occup kind of work done	pation	warkina	16b. Kind of Bu		
2	within one.	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	life.	DO NOT use retire	ed)	rorking			
	ai Hygien other th	7	0	1	Housewife	1			Home	
ng	THE O	17, Fether's Name (First, Middle, Last)				18. Mother's N	leme (First, Middle	, Maiden Sumem	Θ)	
aryland	should by and Menta marked umartic ev	John L.	Walton			Ruth		Lee	2 7. 0	\
Mai	2000	19a. Informant's Name/Relationship (T			ing Address (Stree					000)
	of Health item 27 other tr	William Walton (I	Brother)		5 zion Ro	. Lansd	owne, Ma	ryland 2		n State
יסר	Peges nent of i	1 ■ Burial 2 □ Cremation 3 □ F	Removal from State	metery, cre	metory or other ple					
Baltimore,	it. Peg rtment rtant: it njury o	4 Donation 5 Other (Specify,	100		ill Cemet		7-1-98		yn Pk.	. Maryland
Ba	permit. Peges Department of important: If it any injury or o	21. Signature of Funerel Servica Licans		1	Name end Address McCully-					
_		23a. Party Enter the disease, or comp	llene	Description			Baltimo			21230
5	Physician /Medical Examiner	shock, or heart failure. List only of the control o	OLANZAPINE INT		ION AND DRO	WNING				ntérval Between Onset and Death
o,	te be axecuted ystolen and he buriel-transit	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying	b. Due to (or	as a conse	equenca of):	-				
x 68760,		Cause (Disease or Injury Ihal Initiated events resulting in death) Last	Due to (or	as a conse	quenca oI):					
Вох	attan for u						1			
s, P.O.	requires that the death certifical seen signed by the attending phenould be deteched for use as it should be deteched for Use as it eted by Physician/Med	Part II. Other elgniticant conditions co	ntributing to death but not resu	iting in the i	underlying cause gi	iven in Paπ I.		Yee 2 No	3 Proba	the cause of death?
Records	The law require: sate has been sig, page 2 should b							s en eutopsy formed?	com	e autopsy findings lable prior to pletion of cause eath?
	The law ate has the page 2 s						10	Yes 2 No	10	Yes 2□ No
ta	ysician: The li is certificate ha director, page fo Be Com	25. Was case referred to medical				26. Place of I	Death (Check only	one)		
>	hysici his ce il direc	examiner? XX Yes 2□ No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatie	ent 3 DOA	ther: 4 Nursin	g Home 500 Res	sidenca 6 🗆 Oth	er (Specity)	
Division of Vital	Attending Physician: or death. ector: After this certific by the funeral director, iffication: To Be (27. Manner of Death 1 □Natural 5 □ Pending	28e. Date of Injury (Month, Dey Year)	28b. Time (of A 28c. inju	ury at ork?	28d. Describe	how injury occur	red	
Ö	ath. path. path. patic	2 Accident investigation	FOUND 6-28-98	FOUND9	:50 ^M	Yes 2∭No	UNKNOWN			
<u> </u>	us or Attending P rs after death. at Director: After t led in by the funers Certification:	3 ☐ Suicide 6 💢 Could not be determined	28e. Placa ol injury - At ho building, etc. (Specify	me, fam, s	treet, factory, office		28f. Location City or To	(Street and Numb own, Stete) 152	per or Rurel i	Route Number, AMS AVE.
	tai or as aft		FOUND HOME					RE CITY MA		
	To the Respital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:		elcian: To the best of my know iner: On the basis of examinati							
	thin 2, the parties of the parties o	one)	and manner stated.		200 Lines	aa aumbaa		20d Data alana	d (Month D	ou Voad
	O N O O	29b. Signeture and title of certifier	1			se number		29d. Dete signe	29 ,	1998
		Theodor M.	respub.			ME		JUNE	23,	100
		30. Name and eddress of person who c				2		04000		
		Theodore King M.D. 31. Dete liled (Month, Day, Year)	32 Registrar's Cionat	lura	et, Balti	more, M	aryland	21201		
	State Registrar			Xa.i.Ja	n Randelle					
DH	MH 16 Rev 6/95	JUL 09	1338 June	- THE						



State of Maryland / Department of Health and Mental Hygiene

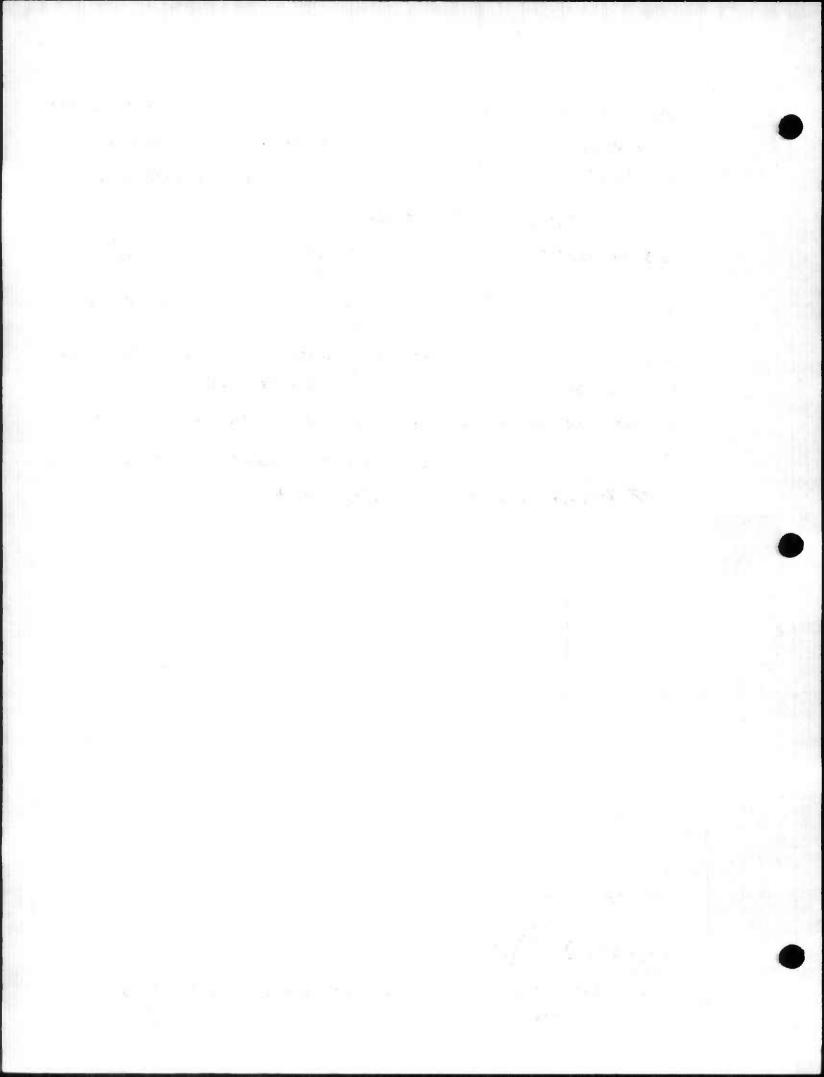
21042

					U	erimcate o	Deam		Reg. No.	
	Physic /Medi		1. Decedent's Neme (First, Middle, Last) Beulah Francis					2. Dete of D Month May	25 ^{Dey} 19	
?	Exami	ner	4a. Facility Name (If not institution, giva stree Eqle Nursing Ho				4b. City, Town, Lonacc	or Location of Dec ning	4c. County Alle	
	Funeral Director		5. Social Security Number 6. Sex 213-22-3323	7. Age	(In yrs. last birthde 89 Yrs.	Months Day		lin. (Month, L	Sirth Dey, Year) 16 1909	9. Birthplace (Steta or Foreig Country) Maryland
	Maryland H show	tor	Usuel Residence of Decedent 10a. Steta 10b. County Md. Allegany		10c. City, Town or Wester					10d. Inside City Limits
	h with the 23a or 28a ast be not	Funeral Director	10e. Street end Number 513 Maryland Av	7e.		10f. Zip Code 21	562	10g. Citizen of V United	What Country? States	
020	be filed within 72 hours after death with the Maryland tial Hyglena. d other than "natural", or items 23a or 23a-1 show event, the Medical Examiner must be incuffed at	by	1 Navar Married 2 Married	Was Decedant E Armed Forcas? I ☐ Yes 2 ☑ No If Yes, Give Yaer or Dalas:	var in U,S.	3. Was Decedent of If Yas, specify Cu 1 ☐ Yes 2 ☑ N		(Specify Yas or Narto Rican, atc.)		e - Amarican Indien, ck, Whita, atc. W White
21215-0020	within 72 ho ena. than "natur	Completed		on m <i>pleted)</i> College (1-4or 5+	(Gi	cedent's Usuei Occ ve kind of work don DO NOT use reti	a during most of (red)			usiness/industry
Maryland 2	정보증	To Be Co	Unknown 17. Fether's Neme (First, Middle, Last) Jesse Michael		ASCC		18. Mother's I		ia, Meiden Suman h	ne)
	12 and	-	19e. Informent's Neme/Reletionship (Type, Christine McKen:			ailing Address (Stre 25 Green	et end Number or le St. T	Rural Route Num Western	port, M	Stele, Zip Code) Id. 21562
Baltimore,	305		20e. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remode 4 □ Donetion 5 □ Other (Specify)	ovei from Stata	cemetery, c	position (Name of remetory or other p	_	Dete - 27 - 98		city or Town, Stata
Balt	permit. Pag Department Important: If any injury o		21. Signatura of Funeral Service Licansea	Su	e	22. Name and Add Boal F	uneral	Home	ernport	. Md.
ox 68760,		n/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	Jener	rue to (or as a consultation of the consultati	dequence of	l Infa Soase osclic	nction		onset and Death Immediat 5 pars
7. C.	requires that the death been signed by the atter should be detached for	/ Physicia	Pert II. Other significant conditions contribu	uting to death but	not rasulting in the	underlying cause	given in Pert I.		d tobacco use co	ntribute to the cause of death
Hecords,	has t	Completed by						_ per	es an autopsy formed?	24b. Were eutopsy findings eveileble prior to completion of cause of death? 1 Yes 2 No
VItal	ician: Th certificata rector, pa	Be	25. Wes case referred to medical exeminer?	0.7				Deeth (Check only	one)	
<u></u>	£ = E	on: To	1 Ves 2 No Hosp	itel: 1 ☐ Inpatien 8e. Dete of Injury (Month, Dey		of 28c. In	jury at lork?		sidence 6 Oth e how injury occur	
Division	Attendar death ector:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 2	8e. Pleca of Injur building, etc.	y - At home, ferm, (Specify)	street, fectory, offic	□Yes 2□No e		(Street end Numb own, Steta)	ber or Rural Route Number,
	Hospita 24 hours Funeral staly fille	edical C	29e. Certifier (Check only one) TO Certifying Physicia 2 Medical Examiner:	n: To the best of On the basis of e end mannar stete	xaminetion end/or	eth occurred et the investigetion, in my	time, date end ple opinion, deeth o	eca, end due to the	e cause(s) end me e, dale end pleca,	enner es stated. end due to the cause(s)
	within 2 To the comple	Me	29b. Signature end title of certifier	\	_	29c. Lice	nse number		29d. Data signe	d (Month, Day, Year)
			30 Name and address of such as	M	(Harrison) (W		7000	7	May 25	, 1998
			30. Name and address of person who compl				Tana	aonin-	M.A. 24	F 2 0
_		$\overline{}$	H. V. HITTES J	L. PlaD	. J/ Jac	KSON_ST	Lona	CODING.	IVIO - ZI	2.19

State

Registrar

JUL - 2 1998



8:45pm

10d. insida City Limits 1 Yas 2 No

16. Mother's Nama (First, Middle, Melden Sumema)

5-28-98

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

Christina Broadwater

Lonaconing, Md. 21539

20c. Location - City or Town, Stata

Dry Run, Md.

29d. Deta signed (Month, Dey, Year) May 26, 1998

Physician /Medical Unknown

Be

17. Fathar's Nama (First, Middla, Last)

19a. informant's Name/Raiationship (Type, Print)

Robert Smith - Son

□ Donation 5 □ Other (Specify)

21. Signatura of Funaral Sarvice Licensae

Buriai 2 Cremation 3 Ramoval from Stata

Porter Smith

20a. Mathod of Disposition

Baltimore, Maryland 21215-0020

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end physician end the burial-transit signed by the certificate hes tirector, page 2 s filled in by the within 24 hours at To the Funeral Discompletely filled

29a. Cartifiar

29b. Signature and title-of gentiller

30. Nama and address of person who

Medical

State Registrar

Division of Vital Records, P.O. Box 68760,

	21. Signatura of Funaral Sarvice License		22. Nama Boa 111	and Address of Fecility 1 Funeral F Church St.	Iome Westernport	, Md. 2	21562	
,	23a. Part1. Entar tha disaase, or compli shock, or haart fallura. List only or	cations that caused tha death. Do na cause on each line.	o not antar tha m	noda of dying, such as cardia	c or raspiratory arrest,	Interv	oximata val Batween ot end Deeth	
	immediata Causa (Final diseasa or condition resulting in daeth)	Intracrang	1 mete	ytares, pri	nery unteraine-	1 6	Mas	
-		Dua to (or as	a consequance	of):				
amin's	Sequantially list conditions,	Dua to for as a	a consequance o	nf):				
ž	if any leading to immediate	B 3 10 (51 110 1	a domocquarioc c	.,				
0	cause. Entar Underlying Cause (Disaasa or injury that initiated avants							
5	rasulting in death) Last	Dua to (or as a	a consequanca o	of):				
Ž.						i		
Ö								
200	Part ii. Other significant conditions con	tributing to death but not resulting	in the underlyin	g causa givan in Part I.	23b. Did tobacco use co	ntribute to the c	ause of death?	
7 703	Hypotension	, Parthetic .	acytic	valva	1 ☐ Yee 2 ☐ No	3 Probably	Unknown	
blered r		prestatie a			24a. Was an autopsy performed?	24b. Wara aut evaliabla completic of death?	prior to on of cause	
5	Atheoseleptu	carray an	ky de	scuse.	1□ Yes 2 No	1 ☐ Yas	2□ No	
0	201 1100 0000 10101100 10 111001001			Zo. Placa of De	ath (Check only ona)			
2	1 ☐ Yas 2 ☐ MO	lospital: 1 Inpatiant 2 ER/C	Outpatient 3	DOA Other: 4 Nursing	Homa 5 Aesidence 6 □Oth	er (Specify)		
arion.	27. Mannar of Death 1		Tima of Injury M	28c. Injury at Work? 1 Yas 2 No	28d. Dascribe how injury occur	red		
	3 ☐ Suicida 6 ☐ Could not be datarmined	28a. Piaca of injury - At homa, building, etc. (Specify)	farm, straat, fact	tory, office	28f. Location (Street end Number or Rural Route Number, City or Town, Stata)			

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

ripleted causa of daath (Itam 23a) (Type, Print)

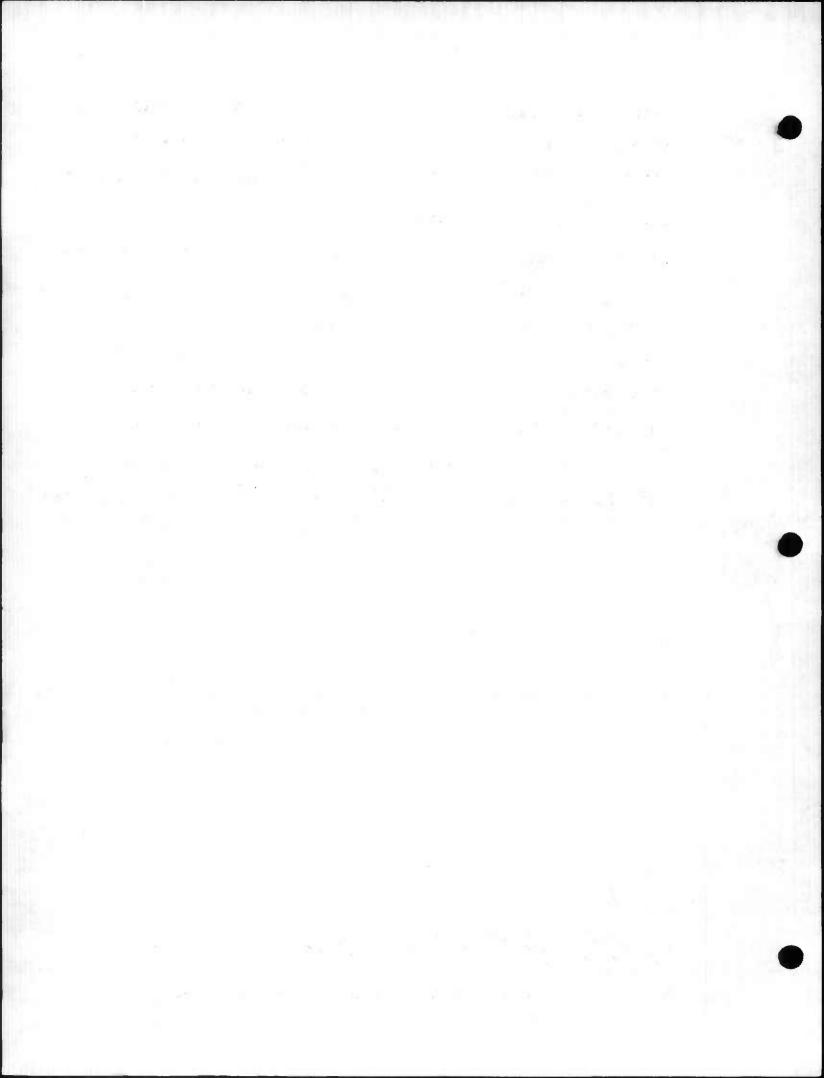
Thomas J. Devlin 20 Douglas Ave. Lonaconing, Md. 21539

29c. License number

67 Douglas Ave.

Broadwater Cemetery

20b. Piace of Disposition (Nama of cematary, cramatory or other plece)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** 106 Salowy /Medical 4a Facility Name (If not institution, give street and number) b. City, Town, or bocetion of Death 4c. County of Death Examiner Kanda Ko town mat la If Undar 24 Hrs. 8. Data of Birth Hours Min. July 12, 1947 If Undar 1 Yaar 5. Social Security Number 6. Sex 10 M 2 ☐ F 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Country) N.Y. **Funeral** Months Days 156-34-3864 50 Director Usual Rasidance of Decedant 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County 1 Yas 2 No Director r 28a-t s Carrol1 Eldersburg 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 8 r than "natural", or litems 23a or the Medical Examiner must be 21784 U.S.A. 1706 Gemini Drive Funeral 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 X No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, etc. 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Dacedant's Education (Specify only highast grada complated) filled within Elementary/Secondary (0-12) nd Mental Hygiens. marked other then Collega (1-4or 5+) 6 Vice President Banking traumatic event. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) th and Mental It Be Pages 1 and 2 should be Anne Sokol John Salony, II 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Charlene Salony Wife 1706 Gemini Drive Eldersburg, Md. 21784 Department of Health Important: If item 27 other 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Other (Specify) 6 7/13/98 Druid Ridge Cem. Pikesville, MD 21. Signature of Fun 22. Nama and Addrass of Facility 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, Md. 21136 23a. Part1. Enter the disaase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical Cardioc Alten Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner eathcular bunal-transit and Sequentially list conditions, if any, laeding to Immadiata cause. Enter Underlying Causa (Diseasa or Injury Ihat Initiatad evants rasulting In daath) Last physician Physician/Medical the Due to (or as a consequence of): 80 esn 50 signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Ware autopsy findings available prior to completion of cause of deeth? Completed Attest Occurred durin 24a. Was an autopsy performed? Cottletaizato Cardia 2 No 1 Yas 1 Yas 2 No certificate Be 25. Was casa refarred to medical examinar? 26. Place of Deeth (Check only one) Hospital: 1X Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No P funaral 27. Mannar of Death 28e. Data of Injury (Month, Day Year) 28c. Injury el Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: Natural 5 Panding invastigation Injury 1 ☐ Yas 2 No 2 Accidant 3 Suicida 6 Could not be datarminad 28a. Piace of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical

certificata be Records, P.O. Division of Vital or Attending Physician: after death. Director: After this certifica

Maryland 21215-0020

Baltimore,

To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

State

Registrar

Joseph Solomon 31. Data filad (Month, Day, Year) JUL 091998

29b. Signatura and titla of certifiar

(Check only one)

8600 Liberty Rd. Randallstown, Md.

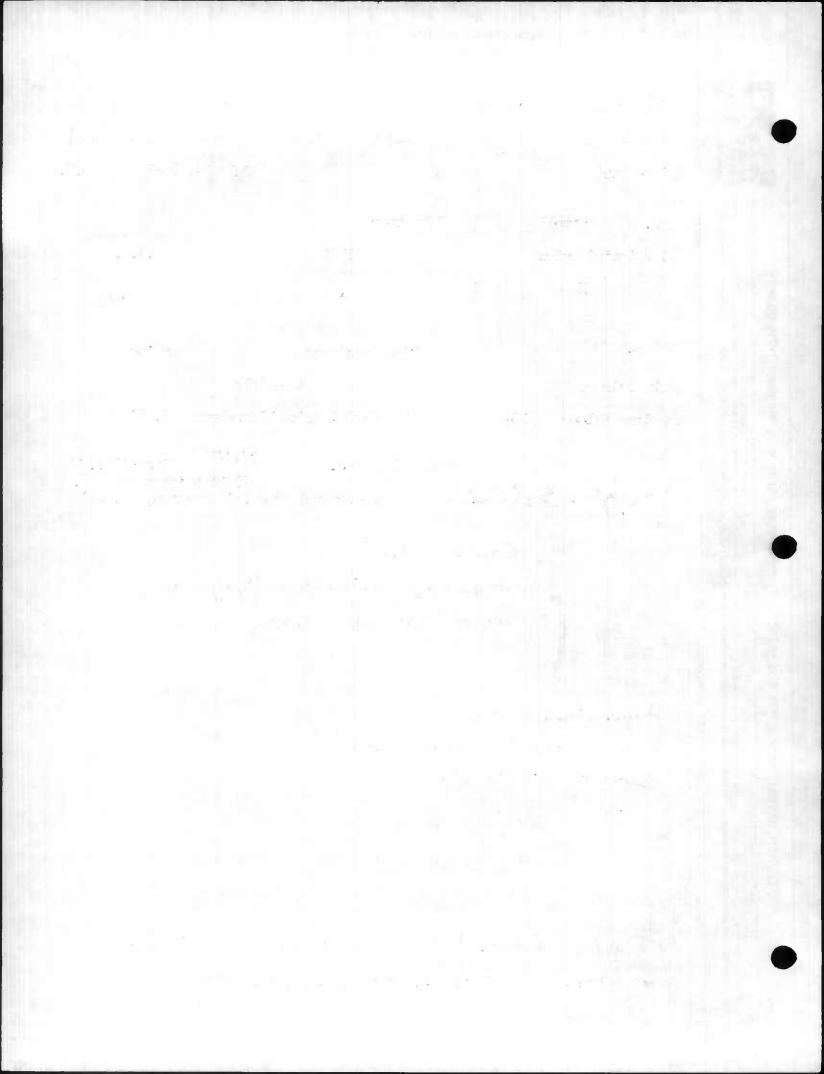
30. Name and eddress of parson who complated cause of daeth (Itam 23e) (Type, Print)

29c. Licansa numbar

29d. Data signed (Month, Day, Year)

21133

2, Registrar's Signature



		r FH Film G761 7-9-98 1. Decedent's Name (First, Middle, L	ast) a	,	ificate of	Dealn	2. Date of De	Reg. No.	3. Time of Deeth
Physicia /Medic	al	MArgaret 4a. Facility Name (If not institution, g	A Sui	+		4b. City, Town, or Lo	July y	Day Day 4c. County	1998 0630
Examin	er	St. Elizabeth				Baltimore	Cation of Death	,	/a
uneral irector					if Under 1 Year Months Days		8. Date of Bir (Month, Da March	3 1917	Birthplace (State or Foreign County) Maryland
2		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Loca	tion				10d. Inside City Limits
Find at	tor	Md. n/		altimore	illori				1 ¥ Yes 2 □ No
it be notifie	ai Director	10e. Street and Number 1616 Marshall	Street		10f. Zlp Code 212	30		10g. Citizen of USA	What Country?
o.l.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Xwidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Y	as Decedent of res, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No Rican, etc.)		ca - American Indian, ck, White, etc. y: White
natur	Completed	15. Decedent's (Specify only highest g Elementary/Secondery (0-12)	Education rade completed) College (1-4or 5+)		nt's Usual Occu nd of work done NOT use retire Wife/do	pation during most of works	Ing	16b. Kind of B HOME OWN	usiness/industry VER
other than		17. Father's Name (First, Middle, Las	(t)	nouse	wite/oo	18. Mother's Neme	(First, Middle,	Malden Suman	ne)
Is marked of raumatic ever	To Be	Herman Meixner					na Lore		
Is ma		19a. Informant's Name/Relationship				t end Number or Run			
ant: If item 27 Is ury or other tra	-	Mary A. Anderso 20a. Method of Disposition		Plece of Disposit	tion (Name of	Ave. Bal	т.		- City or Town, State
lant: If i		1 Bunal 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		cemetery, crema		ery J	uly 11 1998	Brookly	n Park, Md.
Important: if item 27 any injury or other tr once.		21. Signature of Funeral Service Lice	insee	22. 1	McCull 130 E.	ess of Facility Y-Polynia! Fort Ave			
		23a. Part1. Enter the disease, or conshock, or heart failure. List on	implications that caused the de y one cause on each line.	ath. Do not enter					Approximate Interval Between
edical aminer		Immediate Cause (Final disease or condition resulting in deeth)	a Small A			crisa			Onset and Death
ŧ	ner		Due to	(or es e consequi	2ciNon	A			1 day
-trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or es a conseque					
	edical E	that inflieted events	C. CARCINON	(or as a conseque	ENST				Syears
		resulting in death) Last	d	(o) as a solisoque					
the atte	Physician/M	Part II. Other aignificant conditions	contributing to death but not re	esulting In the und	erlying cause g	iven In Part I.	23b. Did	tobacco usa co	entributa to the cause of death?
90	by Phy						10	Yes 2 No	3 Probably 4 Unknown
	Completed b							an autopsy prmed?	24b. Were autopsy findings available prior to completion of cause of death?
page .							10	Yes 2 No	1 ☐ Yes 2 Kar No
	a B	25. Wes case referred to medical examiner? 1 ☐ Yes 2 ② No	Hospital:		- OI	26. Plece of Death			40.00
After the funera	ation: To	27. Manper of Death 1 Naturel 5 Pending 2 Accident investigati	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 declaring the		dence 6 Oth	
To the Funeral Director: A completely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury - At building, etc. (Spec	home, farm, stree	t, factory, office		28f. Location (City or To		ber or Rural Route Number,
To the Funeral Directory filled in by	edicai	29a. Certifier (Check only one) 15€ Certifying P 2 Medical Exe	hysician: To the best of my kr miner: On the besis of exeminand manner stated.	nowledge, death on ation and/or investigation	occurred et the t stigation, in my	ime, date and place, opinion, death occurr	and due to the red at the time,	cause(s) and modate and placa,	anner as stated. and due to the ceuse(s)
Com	Σ	29b. Signature and title of cartifier			29c. Licen	se number		29d. Date signe	ed (Month, Day, Year)
, ,	-	P Willie V	n Mussel	10	0	30185	_	July &	1508
+		30. Neme end eddress of person who	completed cause of death (Its	em 23a) (Type, Pr ろくし		ON NE BA	KTO M D	2122	7
	е	31. Date filed (Month, Day, Year)							

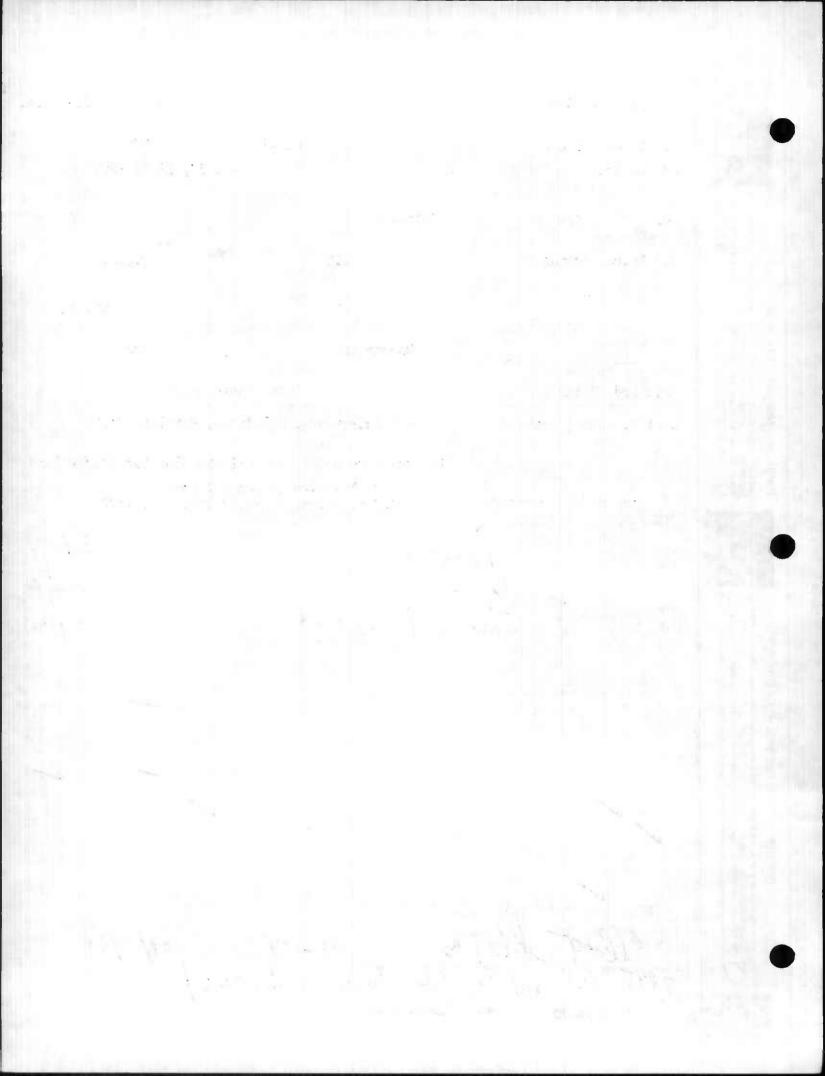
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death July Month **Physician** 7, 1998 Ida B. Samm 6:30 A.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) **Examiner** 416 Audrey Avenue Baltimore If Under 1 Yaar 8. Data of Birth Jan. 18, 1910 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Sacurity Number **Funeral** Days Months Hours Min. 10 M 20 F 220-78-3283 MaryTand 88 Yrs. Director Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or iteme 23a or 28a-f show 1 Yes 2 □ No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Funeral 416 Audrey Avenue 21225 Pages 1 and 2 should be filed within 72 hours efter death nent of Health and Mentel Hygiene. Art: If Ilem 27 is marked other than "natural", or flems 23. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Spacify Specify by 3 □ Widowed 4 □ Divorced White Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT usa retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Home 11th Λ 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Richard Heinz Anna Steegmayer 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. intormant's Name/Relationship (Type, Print) nt of Health a If Item 27 is or other tra Carl C. Samm (Husband) 416 Audrey Ave. Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or ance. 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Park 7/10/98 Glen Burnie, Maryland 21. Signatura of Funeral Sarvica License 22. Name and Address of Facility ٢ McCully-Polyniak Funeral Home 237 E. Patapsco Ave. Balto., Md. 21225
23a. Part1. Enter the disease, or complications that ceusad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onsat and Death **Physician** /Medical immediate Causa (Final disaase or condition resulting in death) Examiner Examiner physiclan and s the bungl-trans Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest requires that the death certificate bejay P.O. Box 68760, Physician/Medical Due to (or as a consequence ot) ettending p signed by the eld be detached for 23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown Records, py 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24a. Was an autopsy aw irector, pege 2 s The 1□ Yes 2Ē No 1 Yas 20 No Division of Vital or Attending Physician: director, 25. Wes case reterred to medicel axaminar? Be 26. Place of Deeth (Check only one) Othar: 4 Nursing Homa 5 Aesidence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this 27. Menne of Deeth 28a. Date of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? 1 Natural 5 Panding death. 1 ☐ Yes 2 ☐ No investigetion after death.

Director: A 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide Funeral D hours a Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier Medical pletely f To the Hor within 24 h To the Fur completely 29b. Signatura and little of certifier 29d. Date signed (Month. Dev. Year) 29c. Licanse numbar h 200 of deeth (Item £3e) (Type, Phint)

32. Registrars Signature

210

State Registrar



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) TILLA 5, 1998 AUDREY ERNESTINE STEIN 1908 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Aga (In vrs. last birthday) 8. Date of Birth 1 M 2 XF Months Days MARYLAND Yrs. 03/03/1918 212-01-8580 80 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a Stata 10b. County 1 Yes 2 No GLEN BURNIE ANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21061 1004 LOUISE DRIVE 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Navar Married 2 □ Married 1 Yes 2 No Specify: Specify: WHITE 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry completed) Elementery/Secondery (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ANNA E. GUNTHER WILLIAM D. BYERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) 405 UNION STREET, ABERDEEN, MARYLAND 21001 CHARLES BYERS - BROTHER 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition Burial 2 Cremation 3 Ramoval from State 4 Dongtiop 5 Other (Specify) 7/9 SYKESVILLE, MD LAKE VIEW MEMORIAL PK. Fulleral Service Licen RAYMOND INC. OF FINK FUNERALHOME OF GLEN BURNIE 426 CRAIN HWY., S.W., GLEN BURNIE, MD 21061 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequenca ot): Due to (or as a consequence of) 23b. Did tobacco use contributa to the causa of death? Part II. Other eignificant conditions contributing to death but not resulting in the undarlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings evallebte prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 N 25. Wes case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 En/Outpatient 3 DOA 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heelih and Mental Hyglene.
Department if them 27 is metked other than "natural", or items 23s or 28s-4 show eny Injury or other traumatic avent, the Medical Examiner mant be notified as

Baltimore, Maryland 21215-0020

the 98 esn 8 page 2 nes.

Physician/Medical Examiner

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Completed

Be

Certification: To

Medical

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homlcide

(Check only one)

29b. Signature and title of certifie

8 certificete or Attanding Physician: director, this funeral after death. Diractor: Aft the n 24 hours after dea ne Funeral Diractor pletely filled in by th

Division of Vital Records, P.O. Box

within 24 hor To the Fune completely fi

the

State

Registrar

31. Deta tiled (Manth Day, Year 1998

5 Pending

investigation

6 Could not be determined

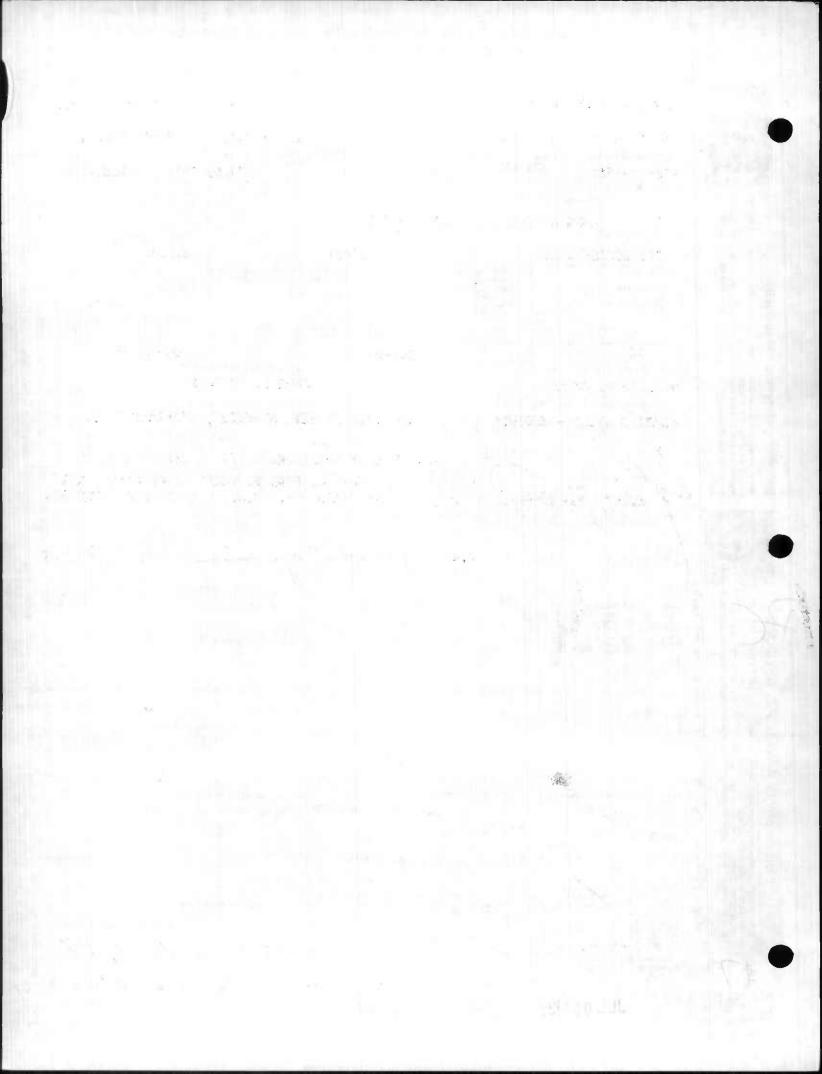


28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

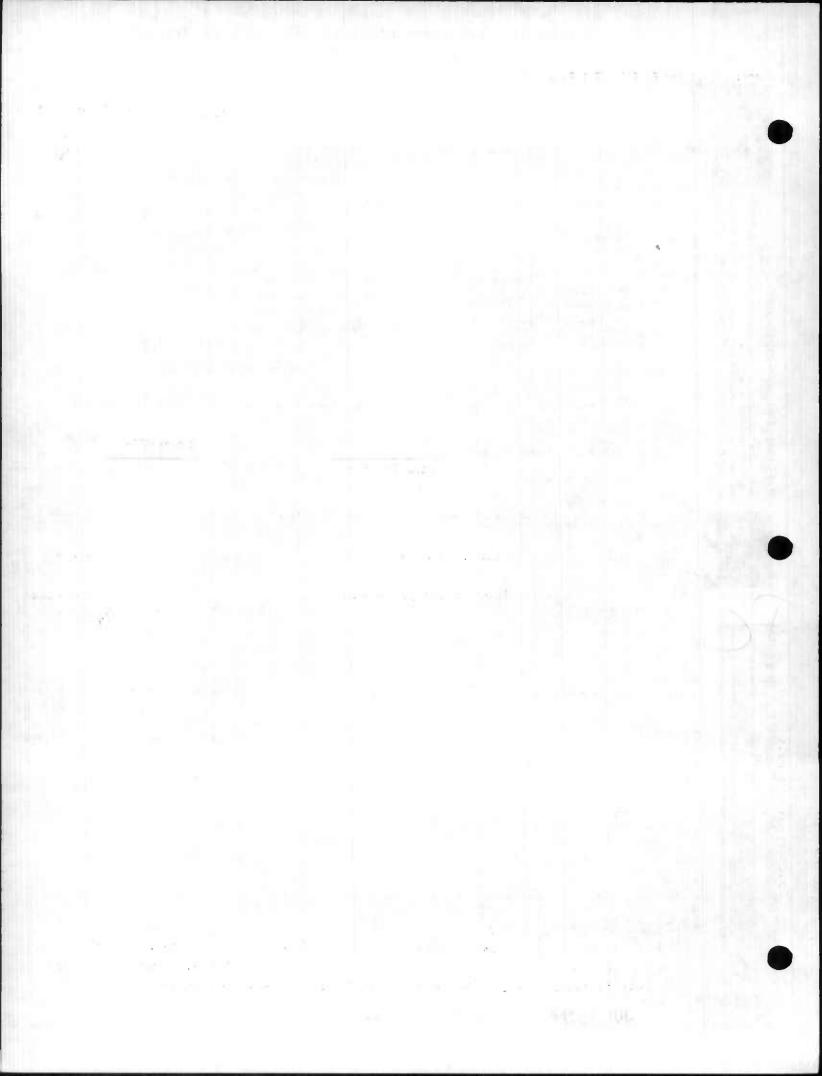
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

So) she



Amend: #20b c	Per FH Film G761 7-9-9	State of Man		ertificate of			giene 8	21048
	1. Decedent's Name (First, Middle, Las					2. Dete of De		3. Time of Death
Physician /Medical	Jimmie Dale Souther					June		1998 10:45 a.m.
Examiner	4a Fecility Name (If not Institution, give St. Agnes Hospital	e street and number)			4b. City, Town, o Baltim	or Location of Deetl	4c. County	
Funeral Director	5. Social Security Number 6. S 213–82–0052	Sex 7. Age (In yrs. last birthdey) If Under Months			If Under 24 H Hours Mi			Birthplace (State or Foreign Country) Oregan
2 .	Usual Residence of Decedent 10a. State 10b. County	11	Dc. City, Town or L	ocation				10d. fnside City Limits
the Marylar 25a-1 show sotified at ector	Maryland Baltimon		Catonsvi					1 ☐ Yes 2 No
3s or 21 st be no	149 Nignnery Lane #A5			10f. Zip Code 21	.228		10g. Citizen of V USA	What Country?
5-0020 72 hours after death with the Maryla natural; or learns 23e or 28e1 show side Examiner must be notified at steed by Furneral Director	11. Maritel Stetus Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Yeer or Detes:	er in U,S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2XXNo		(Specify Yes or No erto Rican, etc.)	Bled	ee - American Indien, ck, White, etc. V: White
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 abould be filed within 72 hours at begarnered of their and Mental Hygionism of them they are marked other than "catural", or my injury or other traumetic event, the Medical Examinate. To Be Completed by F	15. Decedent's Ed (Specify only highest gra Elementery/Secondery (0-12)	ducation ide completed) College (1-4or 5+)	16a. Deci (Giv life.	edent's Usuel Occup e kind of work done DO NOT use retire	pation during most of w d)	vorking		usiness/Industry
d 21 Higher th wher the	10			Cashier	40 54-15-4-5	Same of Change & Control		Mallards
Maryland 2 12 should be filed v n and Mental Hygio 1s marked other t traumatic event, th	17. Father's Name (First, Middle, Last) George E. Souther					a M. Hutton		16)
, Maryla and 2 should selfn and Me n 27 is marks are traumatic	19a. Informant's Name/Relationship (Anna Souther - Mot			ling Address (Street Nunnery La				
Baltimore, N poemit. Pages 1 and Department of thealth important: if item 27 any injury or other to once.	20a. Method of Disposition	Removal from State	20b. Place of Disp cemetery, cri	position (Name of emetory or other pla	ice)	Date	20c. Location - Catonsvill	City or Town, State
Itimo	21. Signature of Funeral Service Licer	y) //	St. Johns Metro Cr	rematory 22. Name and Addre	ass of Facility	he 24 1991	SELLICOTT	City, Maryland
Balti pemit Departm Importa any loju ance	Thumbelli-	10.	M00535			Slack Fune Ellicott C		
Physician /Medical Examiner	23a Part Enter the disease or com- neck, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		is of li		ng, such as cerd	iac or respiretory a	rrest,	Approximate Interval Between Onset and Death
Box 68780, eath certificate to incerted attending president and for use as the burishment	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>Hepatic</u> Du	e to (or as a conse	lopathy equence of):				two weeks
Box death cert attending d for use	Part ii. Other significant conditions of	ontributing to death but o	not resulting in the	underlying cause of	ven in Pert i	23h Did	tobacco use co	entribute to the cause of death?
is, P.O. Box 6 res that the death certific righed by the attending to be detached for use as by Physiclan/Me	Part II. Other significant conditions of	onthibuting to death but h	iot resulting in the	underlying cause gr	von in Port i.		200 140 110115-00	3 □ Probably 4 □ Unknown
requirements the correction of							en autopsy ormed?	24b. Were eutopsy findings available prior to completion of ceuse of deeth?
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	25. Wes case referred to medicel examiner?				26. Place of D	Death (Check only	one)	
Sion of Vita sending Physician: leath. the funeral director, the funeral director, cation: To Be (1 Yes 2 No 27. Manner of Death 1 Neturel 5 Pending	Hospital: 1 💢 Inpatient 28a. Dete of Injury (Month, Dey Y	2 ER/Outpation 28b. Time Injury	of 28c. Inju		Home 5 Res 28d. Describe	idence 6 Oth how injury occur	
Division Officers, Complete or Attending Physical Completely filled in by the funeral completely filled in by the funeral Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		- At home, farm, s Specify)			28f. Location (City or To	(Street and Numb wn, Stete)	ber or Rural Route Number,
be Hospita in 24 hours he Funeral pletely fille edical C		ysician: To the best of miner: On the besis of example and manner stated	eminetion end/or i					
To the within To the comple	29b. Signeture and title of certifier	Morton,	mD	29c. Licen:	se number		29d. Date signe June 22,	od (Month, Day, Year)
5	30. Name and address of person who Bert F. Mortor			ealthCare	900 0			yland 21229
State Registrar	31. Date filed (Month, Day, Year) JUL 0 9 1998	32. Registrar's			, ,,,,,,	Juli Oalo	n_avenue	5



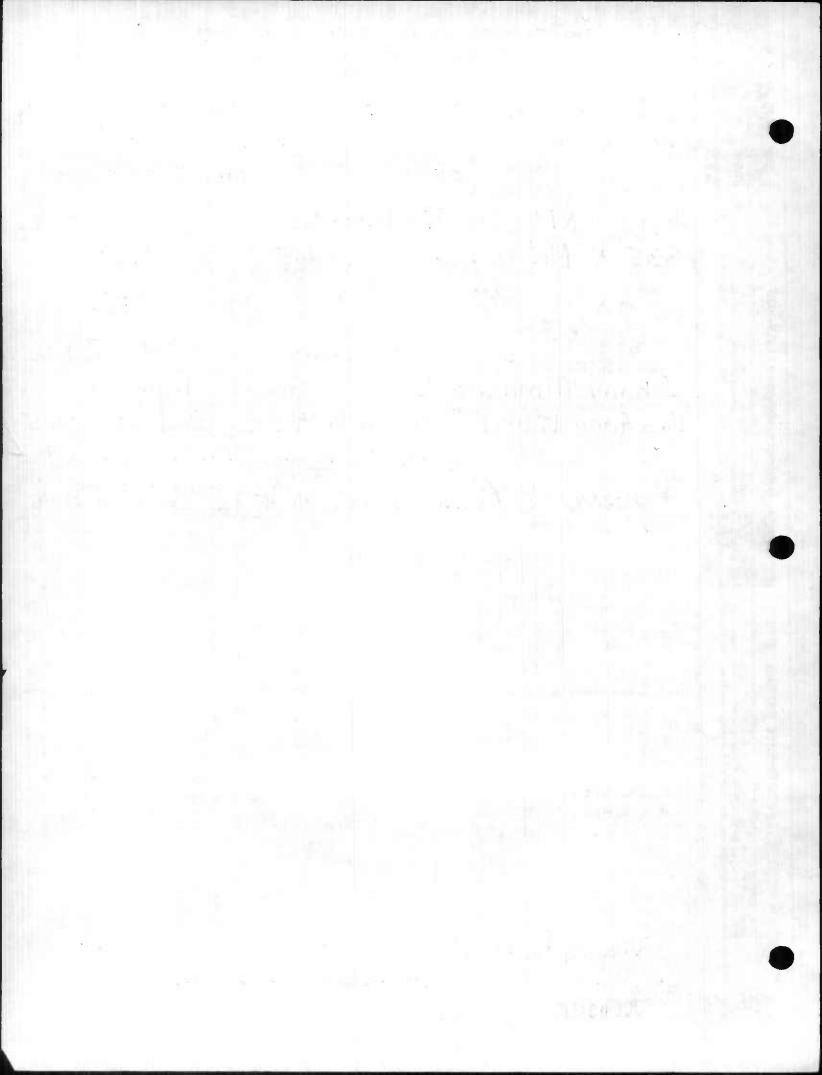
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Stirn **Physician** Month 845pm 1998 624 Donald Jul /Medical 4a. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 1051 Route 32 Howard County Sykesville Hours Min. 8. Deta of Birth May 15, 1923 If Under 1 Yaar 5. Sociel Security Number 7. Aga (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** Months 12 M 20 F MAryland 220-30-0207 75 Yrs. Director Usual Residence of Decedant with the Maryland 10e. Stata 10b. County 10c. City, Town or Location r is marked other than "natural", or hems 23s or 28s-4 show traumatic event, the Madical Examiner must be notified at 10d. Inside City Limits Howard County Director Maryland Sykesville 1 ☐ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1051 Route 32 21784 USA death Funeral 12. Wes Decedant Evar In U,S. Armed Forces? Race - Amarican Indien, Black, White, etc. 11. Maritel Stetus Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) should be filed within 72 hours after and Mental Hygiene.

marked other than "natural", or he 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: Baltimore, Maryland 21215-0020 1 Yes 3 No Specity: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 farmer livestock/grain 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental H ants: If learn 27 is marked oth lury or other traumatic even Mary Grimes August Roy Stirn 19a. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Ms. Donna Lynn Boswell/daughter 8389 Old Frederick Road, Ellicott City, MD 21043 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Important: II any injury or ottos. Lorraine Park Cemetery 9JULY98 Woodlawn, MD 5 Other (Specify) Signature of Funeral Service License 22. Neme end Address of Facility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as o shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical mediate Cause (Final 11 mouth disease or condition resulting in death) Examiner Physician/Medical Examir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): 68760 Due to (or as a consequence of): Records, P.O. Box The law requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ď Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1□Yes 22No 1 ☐ Yes 350 No certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Se Residence 6 Other (Specify) 20 No 2 ↑ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manng of Death Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attar or Attending 1 Natural 5 Pending investigation death 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 5 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (δρεσίγ) 4 T Homicide To the Hospital within 24 hours a To the Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. Ligense number 29d. Date signed (Month, Dey, Year) ho completed cause of deeth (Item 23e) (Type, Print) 11065 Little Partisent Pkny Columbia mo 21044 State Registrar

j	8-3819- hm nk. 98-		Please	* *		le Ink. Assure A	All Copies Are Legi Mental Hygiene	ble.
u			ART I, 27, 28A-F PER	MEO G761 7-24-98 1	R. Certifica	ate of Death	Reg. No.	21000
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	/Medi		Johnny	limmon	S Jr.	th City Town of	JULY 02, 1998	
	Exami	ner	4a Facility Name (If not institution, git CHURCH HOSPITAL	re street and number)			Location of Death 4c. County	or Death
H	Funeral			Sex 7. Age (In yrs		BALTIMO der 1 Year If Under 24 Hrs	8. Date of Birth	9 Birthplece (State or Foreign
н	Director		UNKnown	10KM 20 F 30	Yrs. Month	s Deys Hours Min	March 9,1959	Mary and
	pur *		Usual Residence of Decedent 10e. Stete 10b. County	10c. C	ity, Town or Location		, , , , , , , , , , , , , , , , , , , ,	10d. Inside City Limits
	after death with the Maryland or terms 23s or 28s-1 show canner man be notified at	Funeral Director	Maryland N/	A	Baltin	nore	10.000	1 XYes 2□ No
	23a or	급	225 M	ilton Au	0	Zip Code	10g. Citizen of V	I < A
	er death fterne 23	Dera	11. Marital Status	12. Was Decedent Ever In I	J,S. 13. Wes De	cedent of Hispanic Origin? (\$	Specify Yes or No- 14. Rac	a - American Indian,
0	or its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		pecify Cuban, Mexican, Puer 25 No Specify:	to Hican, etc.) Blac	ck, White, etc.
002	72 hours after "natural", or the	d by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates:				Black
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21215-0020	filed within Hygiene. ther then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Han	dyman	000	d Jobs
	be file d othe svent,	Be C	17. Father's Name (First, Middle, Last	(1	18. Mother's Na	me (First, Middle, Maiden Sumam	ne)
yla	should Ind Meni	2	Johnny II	mmons	Sr.	Glor	ia limn	rons
Maryland	C/ @ 20 4		19e. Informant's Name/Relationship	17 III (cury)	19b. Mailing Addre	ess (Street and Number or R	ural Route Number, City or Town,	State, Zip Code) Md 21205
	Health Hem 27 other tr		20e. Method of Disposition	valker 20b.	Placa of Disposition (/		Date / 20c. Location -	City or Town, State
altimore,	0 - 2		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		cemetery, crematory of	M Gardons	7/9/98 Dund	alk Md -
	permit. Page Department of Important: If any Injury or page.		21. Signature of Funeral Service Lice		22 Name	and Address of Fecility	Lunaral	Home a
m	88 = 88		Joseph	L. Kuss	1 JOSE	Ph L North	Ave. Balto	Md. 21216
			23a. Party Enter the disease, or conshict or heart failure. List only	plications that caused the dec one cause on each line.	eth. Do not enter the m		c or respiratory arrest,	Approximate Intervai Between
	Physician /Medical		Immediete Cause (Finei					Onset and Death
٦	Examiner		disease or condition resulting in death)		or es a consequence			Į.
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	that the death ed by the atte detached for	sicia	Part II. Other significant conditions	contributing to death but not re	sulting in the underlyin	g cause given In Part I.	23b. Did tobacco use co	ntribute to the cause of death?
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ds,	signed d be de	d by					24a. Was an autopsy	24h Were autoney findings
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> =	Physician: this certific ral director,	To	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residenca 6 ☐ Oth	er (Specify)
T E	Ing Pt	on:	27. Manner of Deeth 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury P.	28c. Injury at Work?	28d. Describe how injury occur	red
Division	Attending r death. ector: Affe by the fune	cat	2 ☐ Accident Investigation 3 ☐ Suicide 6 ♣ Could not be		FOUND5:55 ^M	1 Yes 201 No	UNKNOWN 28f. Location (Street and Numb	per or Rural Route Number
Div	after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Spec	nome, farm, street, fact ify) ING	ory, omca	City or Town, State) 100 BALTIMOE MARYLAND	S. BETHEL
	Hospital 24 hours Funeral stely filled	Saic	29a. Certifier 1□ Certifying Pi	nysician: To the best of my kn	owledge, death occurr	ed et the time, date end plac	e, end due to the ceuse(s) and me	enner as stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	one)	miner: On the basis of exemin and manner stated.			urred et the time, date end plece,	
	To the vithin 2 To the comple	2	29b. Signature end title of certifier	11100	:	29c. License number		d (Month, Day, Year)
		-	memorite	megnill		OCME	JULY 0	3, 1998
			30. Name and address of person who			Street, Balt	imore, Maryland	21201
	Sta	te	31. Date filed Whath, Day, Year	. 001-0	eture			
- 10	Registr	ar	201 13 1338	guardanis.	er-Handall			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25 PM Month **Physician** 1998 JULY ETHEL TYLER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Stella Maris Hospice Towson Baltimore County If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days 1 M 2 TF Yrs. 214-14-1451 79 February 22, 1919 Maryland Director Usual Residence of Decedent with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nant of Health and Mental Hygiene.
Int if Item 27 is marked other than "naturel", or Items 23a or 28a-f ehrov by or other traumatic event, his Medical Examinar must be not find at Maryland Harford County Forest Hill 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1905 Jean Court 21050 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian. 11. Meritel Stetus Black, White, etc. 1 ☐ Yes 2 XXXIo If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: by 3 ☐ Widowed ♣ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Beautician UNKNOWN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Henry Allen Dean Mary Ann Griffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diane Gorschboth - Daughter 1905 Jean Court, Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State MBurlal 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Department if important if any injury or ance. St. John's Cemetery July 3, 1998 Ellicott City, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Slack Funeral Home, P.A. M00535 | Ellicott City, Maryland 21043 Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical mmediate Cause (Final disease or condition resulting in death) BREAST CANCER Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the causs of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 45 Unknown signed to Aq 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed page 2 has 1 ☐ Yes 2 No 1 Yee 2 No certificate Hospital or Attending Physician: funeral director, 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Other: ${}_{4\square\,\text{Nursing Home}}$ 5 \square Realdence 6 X Other (Specify) HOSPICE1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending efter death. Director: Aft 1 ☐ Yea 2 ☐ No investigation 2 Accident 3 Sulcide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basia of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only one) To the Within 2 To the 29c. License number 29d. Dale signed (Month, Day, Year) of celtifier 29b. Signeture and time RIL 7 2.89 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Dale filed (Month, Day, Year)

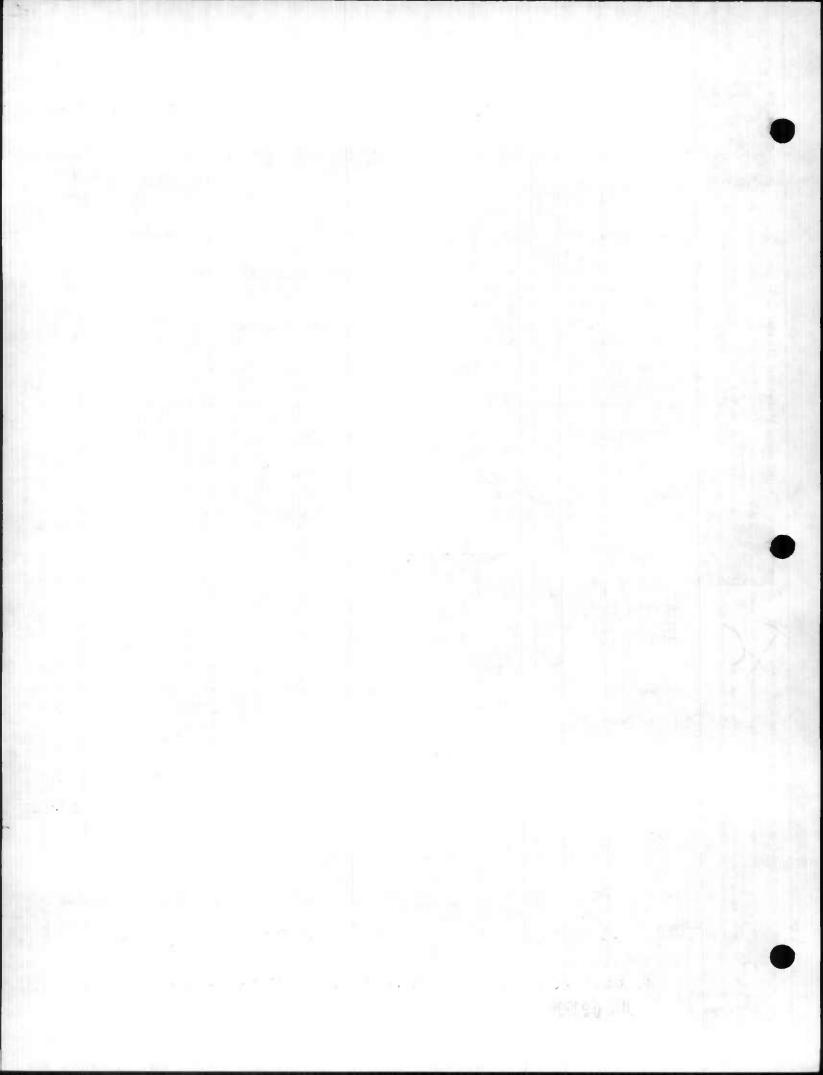
Registrar's Signature

his Davidson-Randale

DHMH 16 Rev 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #31 Per DVR Film G761 7-9-98RC Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth Month **Physician** July 8, 1998 5:40 AM Norval Willard Thomas /Medical 4a. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare - Hamilton Center N/A Baltimore if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) if Under 1 Yeer 5. Sociel Sacurity Number 6 Sex 7. Aga (In yrs. last birthday) **Funeral** Birthplaca (Stata or Foreign Country) 1**⊠**M 2□ F Deys Director 86 215-01-3296 June 25, 1912 Maryland Usual Rasidance of Dacedant filed within 72 hours after death with the Maryland 10a Stata 10b County 10c. City. Town or Location ns 23a or 28a-f show 10d. Insida City Limits 1 Yas 2 □ No Director Maryland N/A Baltimore City 10e. Street end Number 10f, Zip Coda 10g. Citizan of What Country? 21214 United States 5507 Fair Oaks Avenue Funeral Hems ? 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 M No If Yas, Give Yaer or Detas: 11. Marital Status 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2X Married 21215-0020 ŏ 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced 'natural', Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT use retired) Baltimore City than Elemantary/Secondery (0-12) Collega (1-4or 5+) Hygiene. 12 Fire Department Captain Saltimore, Maryland 17. Father's Nama (First, Middla, Last) Pages 1 and 2 should be fill ment of Health and Mental Hiant: If itam 27 is marked oth 18. Mother's Nema (First, Middle, Meidan Sumama) Be Charles Fletcher Thomas Margaret Alice Frasier 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mrs. Barbara Thomas / Daughter Same as item 10e. other 20e. Mathod of Disposition 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cramation 3 ☐ Removal from State = 6 Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) Loudon Park Cemetery 7/10/98 Baltimore, Maryland 21. Signatura of Funaral Sarvica Licansee 22. Nama and Addrass of Facility Leonard J. Ruck, Inc. Funeral Home House 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the disagra, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory errest, shock, or haart failure. List only one cause on each line. Approximeta Intarval Between Onsat and Deeth **Physician** /Medical Immediata Cause (Finel disaase or condition rasulting in daath) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leeding to immadiate cause. Entar Undarlying Ceusa (Disaasa or Injury that initiated events resulting in daath) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 687 Dua to (or as e consequança of) The law requires that the death Pert II. Other significant conditions contributing to death but not rasulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown þ Completed 24a. Was en eutopsy performad? 24b. Wara autopsy findings available prior to complation of cause of death? After this certificate has 1 Yas 20 No 1 ☐ Yes 2 ☐ No Be 25. Was casa rafarred to madical 26. Placa of Daath (Chack only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yes 2∏No Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 2 filled in by the funeral 27. Mannet of Death Certification: 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Attending 1 Natural 5 Panding invastigation death. 1 Yas 2 🗆 No 2 Accident Director: 3 Suicide 6 ☐ Could not be datermined 28a. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide ŏ To the Hospital within 24 hours a To the Funerel C tild Certifying Physician: To the best of my knowledge, deeth occurred et tha time, date and plece, end due to the cause(s) end menner es steted.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred et tha tima, date and piece, and dua to the ceuse(s) and mennar statad. Medicai 29a, Certifian (Check one) 29b. Signature and title of certifie 29c. License number Gamona, h.D pleted causa of deeth (Itam 23a) (Type, Print)
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State Registrar

31. Dete filed (Month Par

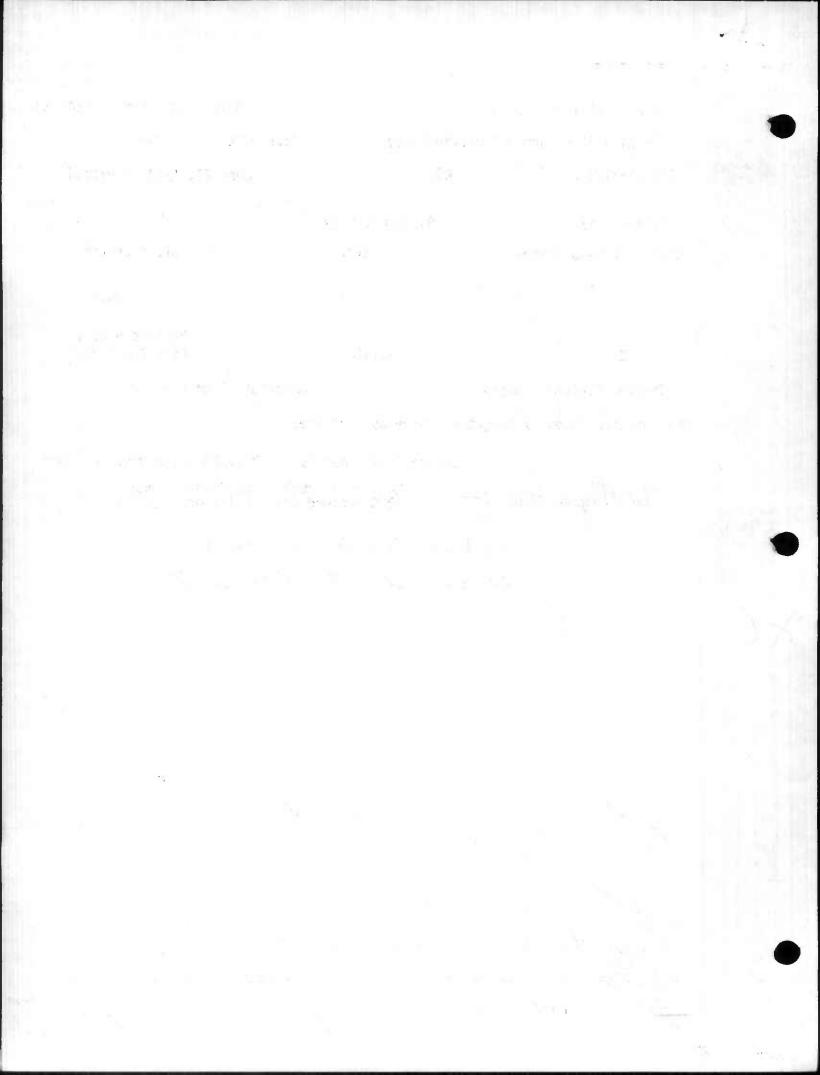
NESTOR

30. Nama and addrass of person who completed causa of deeth (Itam 23a) (Type, Print)

M.

32. Register, Signature

Funda Navidson Andree



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Amend: #7 Per FH Film G761 7-9-98RC 2. Date of Death 3. Time of Death 1. Decedent'a Name (First, Middle, Last) Bertie Estiest Windsor 1988 2:30 1 m 02 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death North Arundel Hospital Glen Burnie Anne Arundel Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) Months Days 82 1 M 2XX Yrs. 217-12-5653 June 15, 1916 North Carolina Usuai Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Maryland Severn 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1673 Shannon-O Circle 21144 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American indian, Black, White, etc. 1 Yes ZNNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Home 8 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Millard Key Sarah Walters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty Lou Schaeffer-Daughter 1673 Shannon-O Circle, Severn, Maryland 21144 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State Ellicott City St. John's Cemetery July 6, 1998 4 ☐ Donetion 5 ☐ Other (Specify) Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 ert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death mediate Cause (Final disease or condition resulting in death) meumoning Days Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of) 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably MUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 0 No 1 Yea 1 No

Physician /Medical Examiner

Physician

/Medical

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Division of Vital Records, P.O. Box 68760

54 To the Within 2 To the

> State Registrar

Pert ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No ☐ Inpatient 2☐ ER/Outpatient 3☐ DOA 28a. Date of injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? 1 Naturai 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier

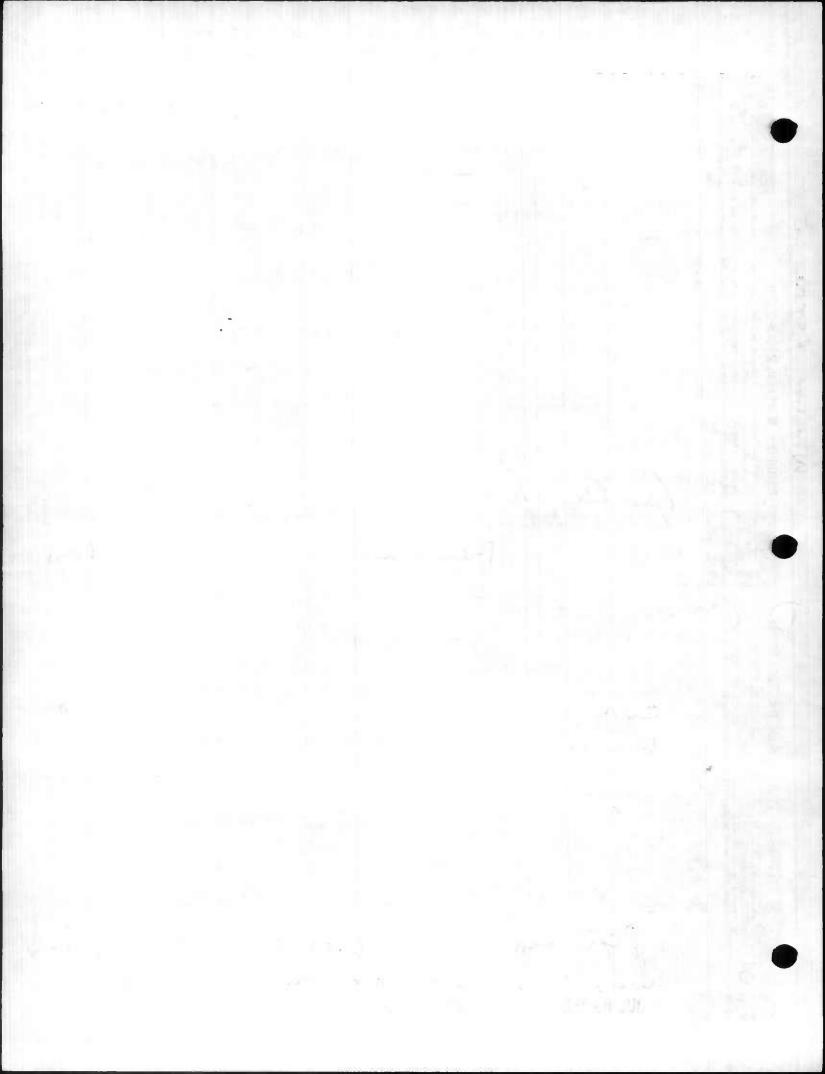
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

290. Signature and title of certifier

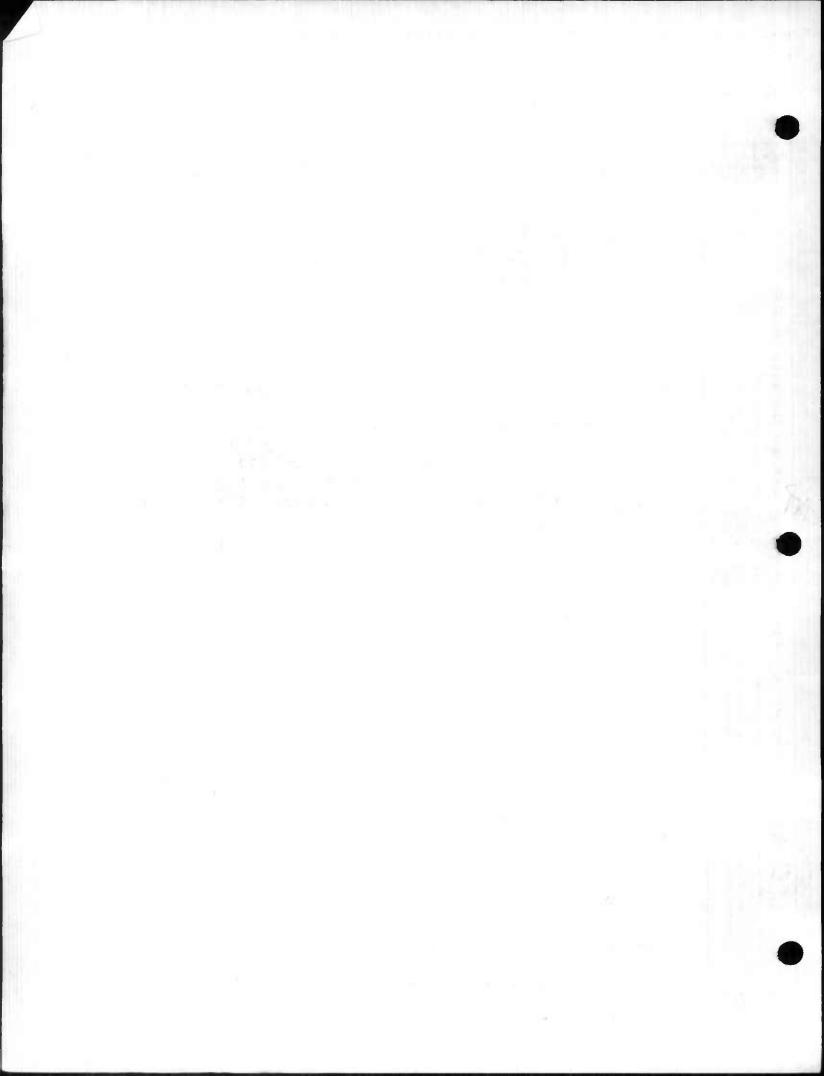
29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nork



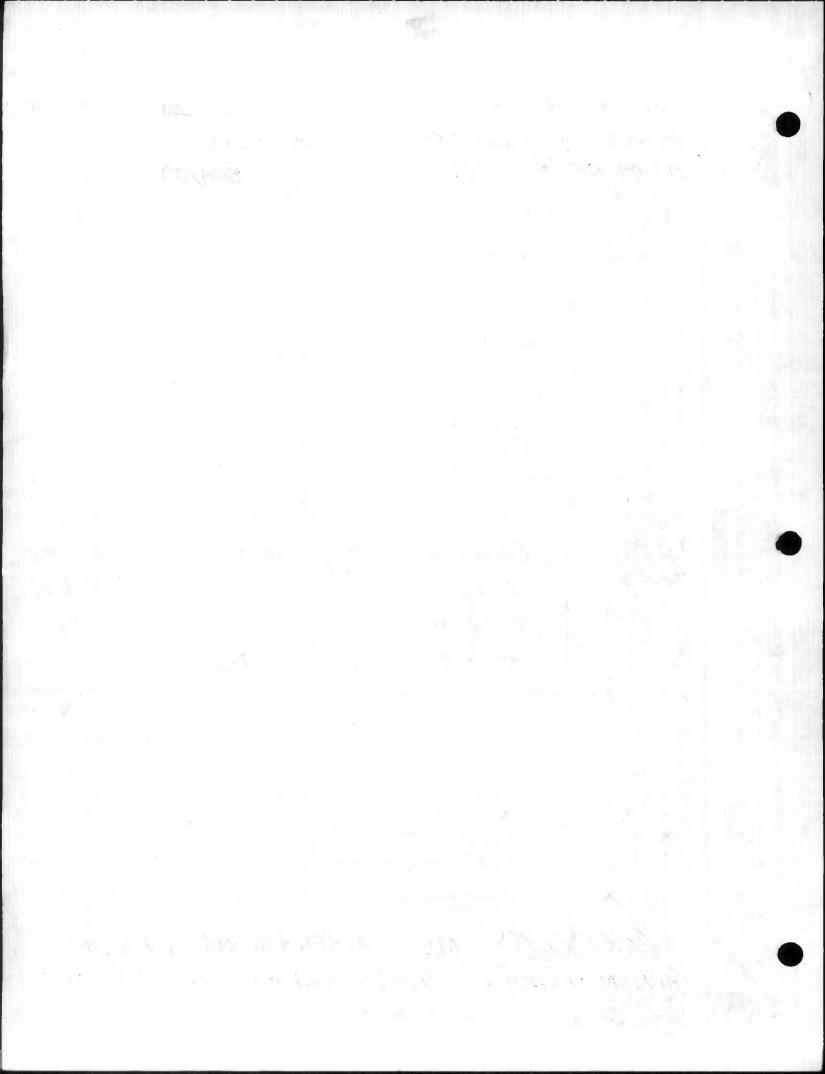
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			State of Maryland / Department of Health and M Certificate of Death		eg. No.	2	055
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oi/	te executed	Exar	Sequentially list conditions, if any, leading to immediate cause. Final Underlying				1011
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	S P		. Congestive heart faile	re		0	nKn.
Box.	0 0 0	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did to	hacco usa con	tribute to t	the cause of death?
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	iras tha signed d be de	d by		ne week	Service I	Oth Was	a autonou findinou
of Vital Records,	w require been si should	Completed		24a. Was a perform		avaii	a sutopsy findings labla prior to plation of ceuse
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/ita	ysician: The secrificata director, pag	Be	25. Was case referred to medical axaminar?	(Check only on			
of	k in in	ဍ	1 Yas No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom				
Lo	Aftar fune	ertification:	27. Mannar of Death 1 Natural 5 Panding (Month, Day Year) 28a. Dete of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 1 Yas 2 No	8d. Dascribe ho	w injury occurre	ed .	
Division	after deeth. Director: Aftar d in by the fune	tifica	3 Suicide 6 Could not be determined 28a. Place of Injury - At home, farm, streat, factory, offica 2		raat and Numbe	r or Rural i	Routa Number,
	ital or ral Olir lled in	O	4 ☐ Homicida building, etc. (Specify)	City or Town	i, Siere)		
	To the Hospital or Attent within 24 hours after deet To the Funeral Director: completely filled in by the	Medical	29a. Certifiar (Check only one) Certifying Physician: To the bast of my knowledge, death occurred et the time, date and place, and check only one) Certifying Physician: To the bast of my knowledge, death occurred et the time, date and place, and place, and continued on the bast of my knowledge, death occurred et the time, date and place, and continued on the bast of my knowledge, death occurred et the time, date and place, and continued on the bast of my knowledge, death occurred et the time, date and place, and continued on the bast of my knowledge, death occurred et the time, date and place, and continued on the bast of my knowledge, death occurred et the time, date and place, and continued on the bast of my knowledge, death occurred et the time, date and place, and continued on the bast of my knowledge, death occurred et the time, date and place, and continued on the bast of my knowledge, death occurred et the time, date and place, and continued on the bast of my knowledge, death occurred et the time, date and place, and continued on the bast of my knowledge, death occurred et the time, date and place and continued on the bast of my knowledge, death occurred et the time, date and place and continued on the bast of my knowledge, date and place and continued on the bast of my knowledge, date and continued on the bast of my knowledge, date and continued on the bast of my knowledge.	d at the time, de	ata and place, a	nd dua to t	he cause(s)
	D V V		29b. Signature and titla of certifiar AV41764350 30. Name end addrass of person who complated cause of daath (Itam 23a) (Type, Print) CARMEN CASTRILLO — 2924 CUILFORD AVE	_866A ²	9d. Dete signed	(Month, Di 30/	98.
	8		30. Name end addrass of person who completed cause of death (Itam 23a) (Type, Print) CARMEN CASTRILLO - 2924 CUILFORD AVE	E, BA	LTO, A	nD'z	1218
	Star Registra		31. Dete filed (Month, Dey, Year) 32. Registrar's Signature JUL 0 9 1998 32. Registrar's Signature				White E



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32. Registrar's Signature

Juna Junidon Randell

State Registrar 31. Data tilad (Month, Day, Yaer) 1998

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Estimate must be notified at once.

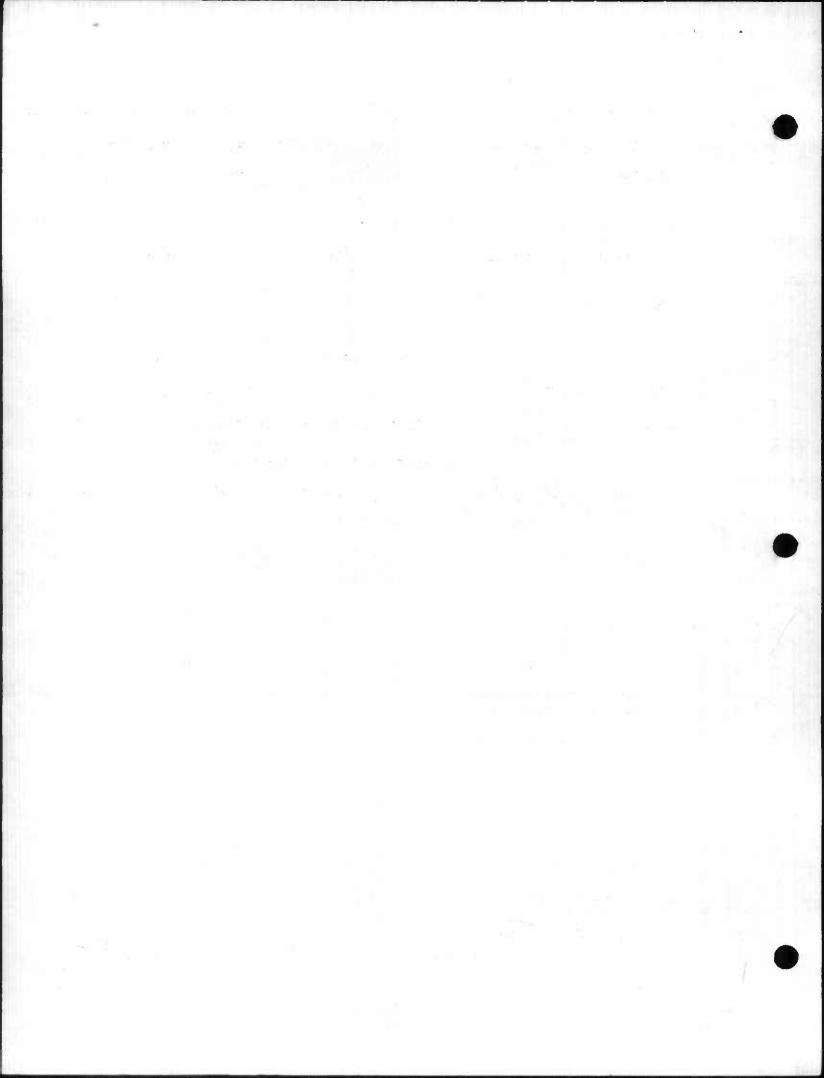
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate Described within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physitian and completally filled in by the funeral director, page 2 should be detached for use as the burnar transit

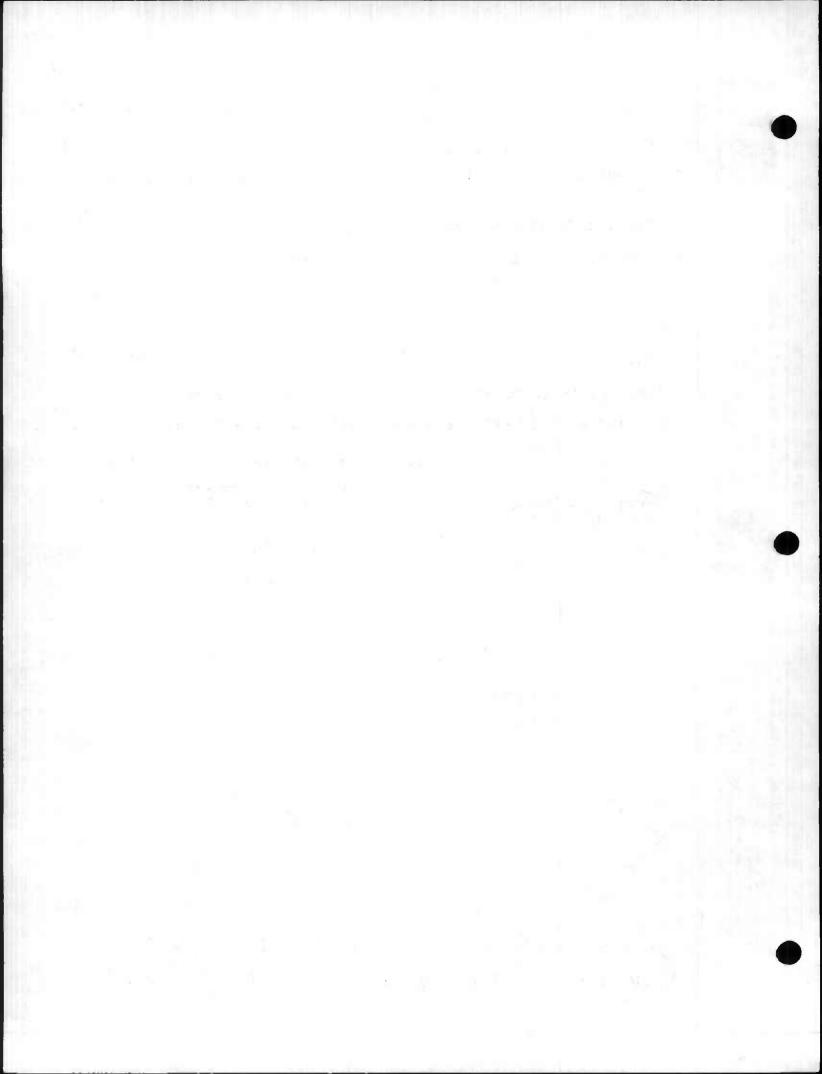
Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene

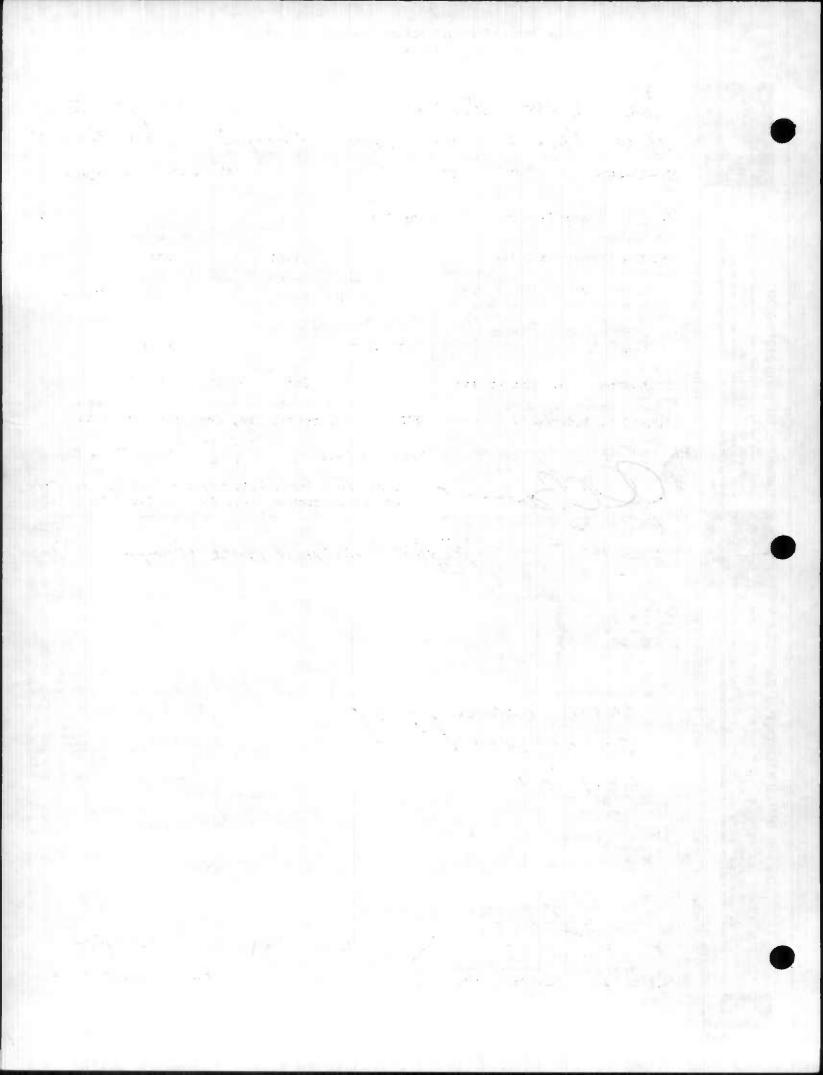
December Heart H							Certifica	te of	Death	R	eg. No.	600	1057
Description	П			1. Decedent's Neme (First, Middl	le, Last)					2. Dete of Deet	th	V	3. Time of Death
## Facility Number (First antitudes, or present antitudes) ## Facility Number (First antitudes) ## Facilit				JESSE L.	ANDERSON								5:30 pm
Social Section Number 2 Section 1 Section 2 Se				4e. Fecility Neme (If not institution	n, give street end number)				4b. City, Town, or I	ocation of Deeth	-		,
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It director, page 2 should be detached for use as the bunk-transit and page 2 should be detached for use as the bunk-transit. To Be Completed by Physician/Medical Examiner	See if it can be	was case referenced to the control of the control o	(Final on Millons, mediate strying injury s Last Illicant conditions Tred to medical No th S Pending Investiga 6 Could no determine 1 Certifying 2 Medical Es	b	Due to Due to	(or es e conse (or es e conse (or es e conse esulting in the (b) (conse e conse (conse esulting in the (conse esul	equence of): equence of): equence of): underlying ca finet 3 DO/ of 28 M street, factory, ath occurred a investigation, 29c.	ause given A Others Bc. Injury a Work? 1 Ye, offica	such as cardiad (CLUM	23b. Did 1 24a. Wa perl ath (Check only) lome 5 □ Res 28d. Describe 28f. Location City or To	I tobecco use of tobe	contribute 3 Pro 24b. Vec 00 11 where (Specurred	Approximate Interval Between Onset and Death Onset of Death O

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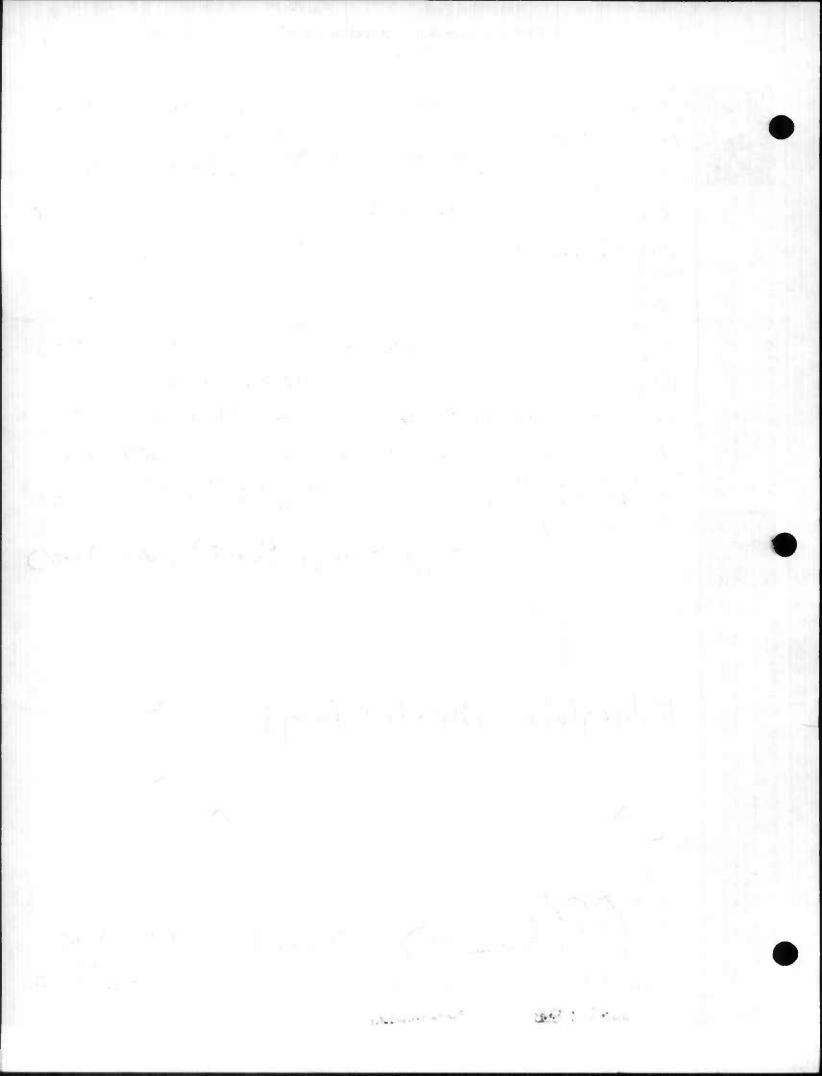
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First Middle Last) 2. Data of Deeth **Physician** ALLEN JUNE DOROTHY REBECCA 7:00 am 11 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death FREDERICK Examiner IJAMSVILLE 9723 THOMPSON DRIVE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 9. Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 💢 F 21 76 214-16-1375 Yrs. Director Usual Rasidance of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Medical Exact for must be notified at MD. FREDERICK IJAMSVILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 21754 9723 THOMPSON DRIVE U.S.A. death Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ∑ No If Yas, Giva Year or Datas: Wes Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health end Mental Hygiene. Int: If Item 27 Is merked other than "naturs!", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK by 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) MARRIOTT CORP. FOOD SERVICES 12 TH 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) THOMPSON NATHAN HALL RACHEAL 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code)
ER) 201 MAPLR AVE. FREDERICK, MD. 21701 19a. Informant's Name/Reletionship (Type, Print) permit. Pages 1 and 2 s Department of Health er Important: If Item 27 is any injury or other trau GLORIA MILLBERRY (DAUGHTER) 20b. Place of Disposition (Nama of cematary, cremetory or other place)
FAIRVIEW CEM. 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 17 JUNE 98 FREDERICK MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensea 22. Nama end Addrass of Fecility
GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST. FREDERICK MD. 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, one and failure. List only one cause on each line. Approximate Interval Batwo **Physician** ansing Heart Dismise /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Due to (or as consequence of) Examiner Saquentially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Diseasa or injury that initiated events rasulting in daath) Last and Dua to (or as a consequenca of): Box 68760. physiclan Physician/Medicai the Dua to (or es e consaguance of): Part Jl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, þ 24b. Wara autopsy findings evallabla prior to completion of cause of daath? should should 24a. Was an eutopsy performed? Completed page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificete To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was casa raferred to medical axaminar? Be 28. Plece of Deeth (Check only ona) 1 Yas 2 Hospital: Other: 4 Nursing Home Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Rasidance 6 □Othar (Specify) 27. Manner of Daath 28d. Dascribe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending Invastigation 1 Yas 2 No 2 Accidant 6 Could not ba determined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) 28a. Place of injury - At home, ferm, straat, fectory, office building, atc. (Specify) 4 Homicide 29a. Cartifian 👊 an: To tha bast of my knowledge, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as steted. ilner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29b. Signatura a nd title of ce 29c. Licensa numbar 29d. Date signed (Month, Dey, Yaar) 30. Nama and address of parson who completed cause of death (Itam 23a) (Type, Print) 97 21 ICK, MD, 2170 CASPER E. CLINE, MD 31. Data filad (Month, Day, Year)

Registrar **DHMH 16 Rav 6/95**

State

JUN 1 8 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene A.A.CO. HEAL Gartificate of Death AMEND: #20b 6/11/98 mcg 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** LeGrand 3:40 AM 8, 1998 /Medical June 4a. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 1439 Bayhead Road Annapolis Anne Arundel If Under 1 Yeer If Under 24 Hrs.
Months Days Hours Min. 5. Sociei Security Number 8. Date of Birth (Month, Day, Year) April 20,1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days **™** 2□ F 216-22-1143 70 Yrs Director Indiana Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Nam 27 is marked other than "natural", or frams 23a or 28a-f ahow other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Md. Anne Arundel 1439 BayHead Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pagas 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural" ~ "nan Injury or other traumatic avairable. 21401 Funeral U.S.A. 1439 Bay Head Rd 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ X 'es 2 □ No
If Yes, Give
Yeer or Detes: 1946-1948 Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Stetus 1 ☐ Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Architect Health Facilities 17. Father's Name (First, Middle, Last) 16. Mother's Name (First, Middle, Maiden Surname) Be 2 Leon G. Benefiel Edna LeGrand 19a. Informant's Name/Reletionship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1439 Bay Head Rd. Annapolis, Md. 21401

20b. Place of Disposition (Name of Crown State Cro Joanne Benefiel (spouse) 20a. Method of Disposition 1 ☑ Burlat 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Inc. 147 Duke Gloucester St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between **Physician** LUNG CANCER /Medicai Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): attanding p been signed by the a should be detached i Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. ٥ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No cartificata Hospital or Attanding Physician: ' 24 hours aftar death. Funeral Director: Aftar this cartifica funeral director, 25. Was case referred to medical Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth Certification: 26b. Time of 26d. Describe how injury occurred 1 Malural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th 3 ☐ Suicide 26f. Location (Street and Number or Rural Route Number, City or Town, State) 26e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

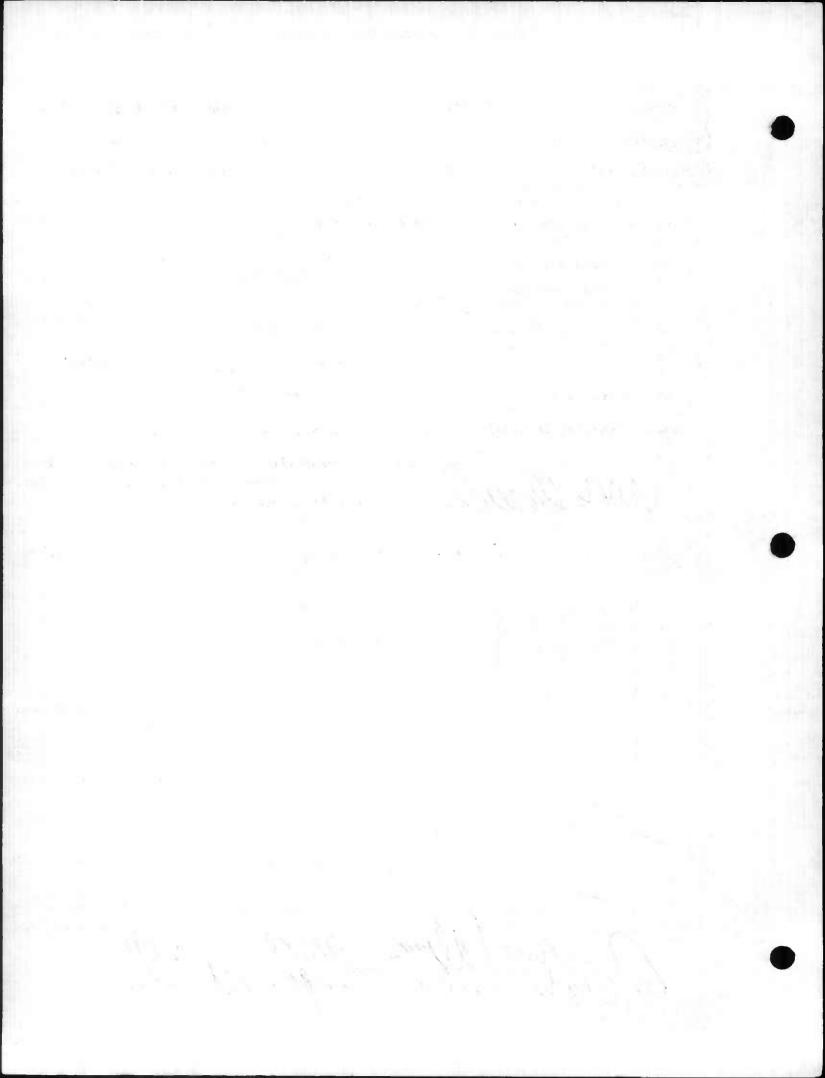
Richard Colgan, MD

State Registrar 30. Name and address of person wh

31. Date filed (Month, Day, Year)

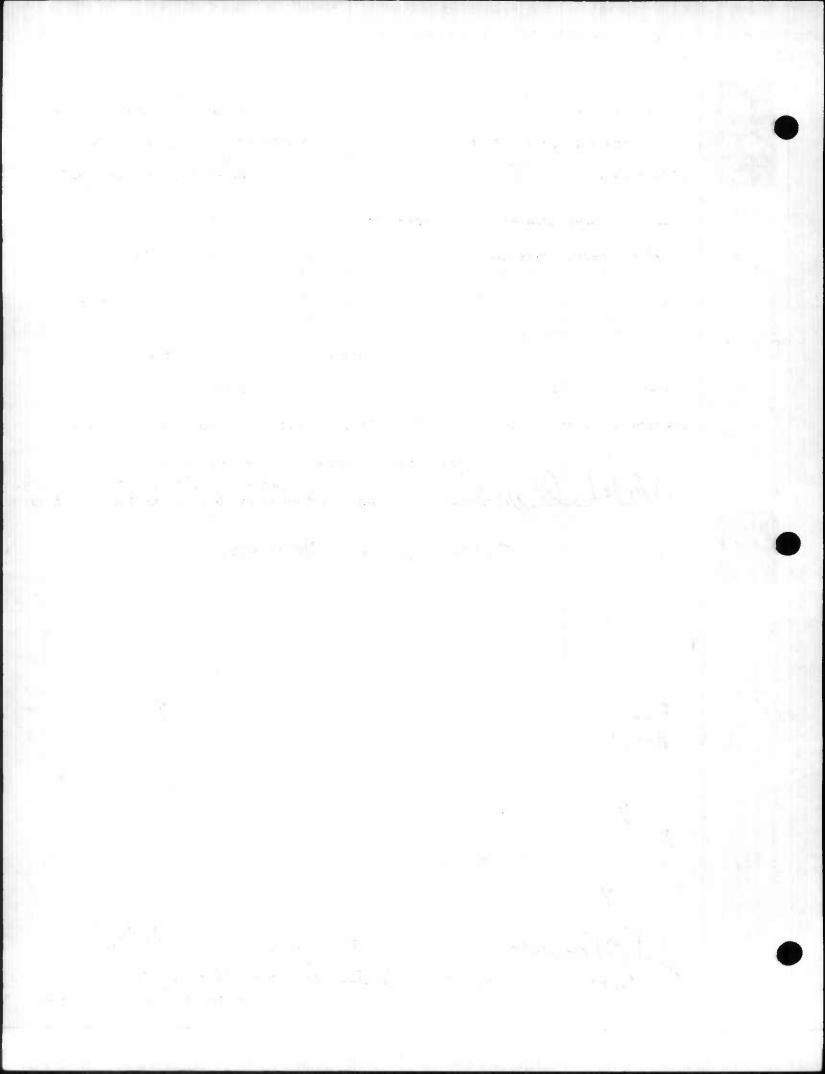
32. Registrar's Signeture

whia Davidson



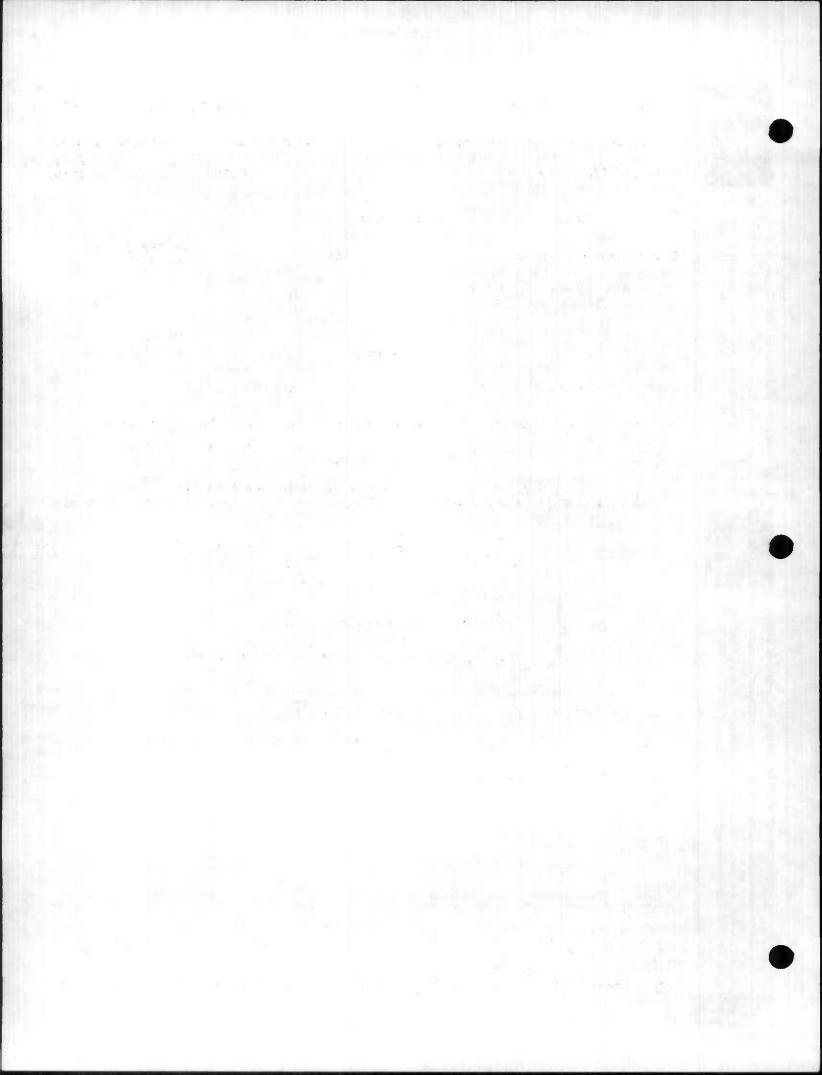
State of Maryland / Department of Health and Mental Hygiene 98 2 1 0 6 1

					Certifica	ate o	f Death	F	Reg. No.	611	101
Dhualaian		1. Decedent's Name (First, Middle, Las	t)					2. Date of Dea	ith Day	3. T	Time of Death
Physician /Medical	_	Fay I. Baker						June	9 199		2:30 PI
Examiner	_	4a. Facility Name (If not institution, give	street end number)				4b. City, Town, or		4c. County	of Death	
	4	Anne Arundel Med			1		Annapo.			Arundel	
Funeral Director		5. Social Security Number 212-70-4937 Usual Residence of Decedent	ox 7. Age □M 2\\\ F	94	Yrs. If Unc	s Dey		(Month, Dev	7 Year) 19,1904	9. Birthpiece (S Country) Maryla	
2 A 11	- 1-	10a. State 10b. County		10c. City, Town	or Location					10d. ins	side City Limi
or or	5	Md. Anne An	undel	Ann	apolis					15	Yes 2 N
23a or 28a-f si at be noticed		10e. Street and Number 205 S. Cherry Gi	rove Ave.		10f. 2	Zip Code	21401		10g. Citizen of W USA		
The marked other than "natural", or freme 23a or 28a-f show traumetic event, the Modeal Examiner must be notified at Taumetic event, the Modeal Examiner must be notified at To Be Completed by Funeral Director	2	11. Maritai Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Decedent Et Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:		13. Was Dec if Yes, s _i 1 ☐ Yes		Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Blec Specify	e - American ind kk, White, etc. White	
tel Hygiene. d other than "natur. avent, ins Medical Be Completed	hiptore	15. Decedent's Ed (Specify only highest grad Elementery/Secondary (0-12)	ucation de completed) College (1-4or 5+		Decedent's Us (Give kind of v life. DO NOT	vork don	e during most of wor	king	16b. Kind of Bu	usiness/Industry	
dien in the	5	12		<u> </u>	Homen	iakei	r		Own h	iome	
Be Sent		17. Father's Name (First, Middle, Last)					18. Mother's Ner	ne (First, Middle,	Meiden Sumem	Θ)	
Men Men	2	Arthur T. Basil					Mary I	ola Cox			
is m		19a. Intormant's Neme/Relationship (7		19b	Mailing Addre	ss (Stre	et end Number or Ru	irel Route Numbe	r, City or Town,	Stete, Zip Code)
of Health Nem 27 is r other tra		Richard A. Baker /	Son				Grove Av				L401
Department of H important: If its any injury or ott		20a. Method of Disposition 1 ☼Buriai 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,			Disposition (A y, cremetory o			Date		City or Town, St	
in lun	ŀ	21. Signature of Fugeral Service Licens		JSE. A	nne's C	eme I	ress of Facility	5-12-98	Annapol	.1s, Md.	-
Departin Importa any inje		·VWHal	laux		147 Du	ike o	ress of Fecility Joh of Glouces	n M. Tay ster St.	lor Fur Annapo	neral Ho lis, Md	me, I
m and tel-transit Examiner		Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions.	b	Que to (or es a due to (or es a d	consequence	():	LURINA	RY			
attending physician and if for use es the burlet-transit clary Medical Examir		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	c	ue to (or ss a c	onsequenca o	r):					
d for		Part il. Other significant conditions co	ntributing to death but	not resulting in	the underlying	Callea C	riven in Part i	23h Did t	obacco una cor	ntribute to the c	ause of de
been signed by the attending physician and thould be detached for use as the burlet-transieted by Physician/Medical Exami		PVD	Thioding to death out	TIOC TOSCIONING II	the underlying	y cause y	green ar Fait I.	1 🗆 1	1	3 Probably	4 □ Unkn
		ASOVD						24a. Wes a	an autopsy med?	24b. Were aut available completion of death?	prior to on ot cause
page 2								1 🗆 Y	es 2 No	1 ☐ Yes	20 No
this certificate ral director, pag.: To Be Co.		25. Wes case referred to medical					26. Piace of Dea	ath (Check only o	ne)		-
his certific		exeminer?	Hospitei: 1 npatien	t 2 ER/Ou	tpatient 3	DOA	Other: 4 Nursing H	lome 5 Resid	lenca 6 Othe	er (Specify)	
After fune		27. Manner ot Death 1 Naturei 5 □ Pending 2 □ Accident investigation	28a. Date of injury (Month, Dey	Year) 28b. T	ime of njury M	28c. inj W	ury at ork? □ Yes 2 □ No	28d. Describe h	ow injury occurr	ed	
within 24 hours effer death. To the Funeral Director: Affer t completely filled in by the funeral Medical Certification:		3 Suicide 6 Could not be determined	28e. Placa ot injur building, etc.	y - At home, fa (Specify)	rm, street, fact	ory, offic	8	28t. Location (5 City or Tow		er or Rural Rout	e Number,
in 24 hour pletely fill edical		29a. Certifier (Check only one)	sictsn: To the best of Iner: On the basis of e and manner state	xamination and	, death occurre Vor investigati	ed at the on, in my	time, date end place opinion, deeth occu	, and due to the or rred at the time, o	cause(s) and ma dete end place, a	nner as steted. and due to the c	euse(s)
To the comp		29b. Signature and title of ceptiller			2	9c. Lice	nse number		29d. Dete sone	Month, Dey, Y	(ear)
		> Hokels	MD			D3	5259		6/9	198	
	1	30. Name and authors of person who c	ompleted cause of dec	eth (Item 23e) (Type, Print)	1.	A	11	· . /	7	
		KEVIN J.	OKEFE	MD	Clot	TW	SHRUNDE	ZMED	orcal C	SYTER	
State		31. Dete filed (Month, Day, Year)	32. Registrar	MD	CO f	two.	ARUNDE	Auna Auna	policy	Mo. Z	:1



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			Otate 0	i Maryland /		ificate of			Reg. No.) (.,	100	_
Dhu	sician	1. Decedent's Neme (First, Mic			400			2. Dete of De Month	Dev	Yeer	3. Time o	
	edical	Harvey	Buchanan					June 3			9:44	P.M.
Exa	miner	4e Fecility Neme (If not institut					4b. City, Town, or I					
		Washington A	Adventist H	lospital 7. Age (In yrs. lest	hidhday	if Under 1 Yeer	Takoma P				y Cour	4
Fune Direc		089-36- 5370 Usual Residence of Decedent	1 M 2 □ F	51	Yrs.	Months Deys	Hours Min.	(Month, De	r 25,194	6 Ne	w York	alo,
anylend		10e. Stete 10b. Cour New	nty	10c. City, To	own or Loc	ation				1	Od. Inside C	City Limits
the Maryle	ctor	York Er:	ie	Nort	th Co	llins					1 X Yes	2 □ No
w it	Funeral Director	10e. Street and Number	d Avenue			10f. Zip Code 1411	1					
20 after dea or items	by	11. Maritei Status 1 Never Married 2 M 3 Widowed 4 Divorce	erried 1 ☐ Yes	/8		/es Decedent of It Yes, specify Cub ☐ Yes 2 🖾 No	lispanic Origin? (S en, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Specify	ck, White,	ean Indien, etc.	
5-00	pete	15. Deced	ent's Education hest grade completed)	16	(Give k	ent's Usuel Occup	during most of wor	king	16b. Kind of B	usiness/In	dustry	
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other th	ပိ	17. Fether's Neme (First, Midd.	ie (ast)		Obse	rver	18. Mother's Ner	ne (First Middle			ring	
Maryland d 2 should be filed the and Mental Hyge T is marked other	Be	Charles Buchar					Onabel1			,		
should b	T _o	19e. Informent's Neme/Reletion	ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
		Darlene Hearn		6	6870	Revere D	rive, De	rby, New	v York	1404	7	
S S	5	20e. Method of Disposition 1		20b. Plece ceme	of Dispos etery, crem	ition (Neme of etory or other ple Cemeter	ce)	June 8,	Hambu New Y	City or To		
Baltimo	DDCe.	21. Signature of Funerei Servi	dAlan	sen	J.	155 Orch	Cannan F ard Park	, Orchai	rd Park,	New	York	14127
Physici /Medic Examin	er jer	23a. Pert1. Enter the disease shock, or heart failure. L Immedlete Ceuse (Finel disease or condition resulting in deeth)	or complications that colst only one course on e	Aused the deeth. Deech line. Due to (or es	Pu	mon		Correspiratory e			Approxime Interval Be Onset end	ote Intween Deeth
cords, P.O. Box 68760, requires that the death certificate be executed seen signed by the ettending physician end hould be deathed for use as the build-lights in hould be deathed for use as the build-lights.	T T	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest	6. The	Due to (or es rombo Due to (or es tropes	e consegu	HODE of):	nia l b1	ees	e			
O. E	sici	Pert II. Other significant cond	itions contributing to d	eath but not resulting	g in the un	derlying cause gi	ven in Pert I.	23b. Did	tobacco use co	ntributa t	o the cause	of death?
P.O.	P.	- Kepa	in of	Lemo	ral	art	ley	10	Yes 2 No	3 Pro	bably 4	Unknown
Division of Vital Records, P or Attending Physician: The law requires that after death. Director: After this certificate has been signed in by the fundral director range? should be deather.	Completed by Physician/M	- Severe	atherosc	lerohic	h	eart	disea	Se 24e. Wes	s an autopsy ormed?	6/	ere eutopsy relieble prior empletion of	to
Vital Rec	dwo	- Hear	t- Jan	line	2		2 2 7	10	Yes 20 No		deeth? □ Yes 20	7 No
tal	BeC	25. Wes case referred to medi	cal				26. Plece of De	eth (Check only				
of Vita Physician:	10 8	examiner?	Hospitel:	Inpatient 2 ER/	Outpatient	3□ DOA Ot	her:			ner (Speci	(y)	
ion of ading Physics After this attraction of tuneral disperse of	atlon: 1	27. Manner of Death 1 Natural 5 Pen 2 Accident inve	28e. Dete		b. Time of Injury	28c. Inju Wo	Other: 4 Nursing Home 5 Residence 6 Other (Specify) Injury at Work? Yes 2 No					
Divis	edical Certification:		ld not be irmined 28e. Plece buildi	et, fectory, office	t, fectory, office 28f. Location (St City or Town			ber or Rur	ai Route Nu	mber,		
Division of whending Phywithin 24 hours after death. To the Funeral Director: After this compleated lined in by the funeral	edical	29e. Certifier (Check only one)	ying Physician: To the al Examined On the b end men	n occurred et the time, date end plece, end due to the cause(s) end menner es stated. vestigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s)			(s)					
Tot	Σ	29b. Signeture and title of certi	all ?			29c. Licen	2378		29d. Dete signe	d (Month,	Day, Year)	
		30. Name end ederess of person	31 Sho	e of deeth (Item 23	e) (Type, F		Carroll A	venue,	rakoma P	ark,	Maryl	Land
Reg	State istrar	31. Dete filed (Month, Day, Ye.	1 0 1998 32. F	fisha Davids		rdell.						



State of Maryland / Department of Health and Mental Hygiene 9 8 2 1 0 6 3

				,	Certificate of	Death	R	eg. No.	2.1000	
		1. Decedent's Name (First, Middle, I	ast)				2. Dete of Dear	th Day Yes	3. Time of Deeth	
	Physician /Medical	Charles Harol	d Bosley				June 1	3, 1998	10:16 P.M.	
	Examiner	4a Fecility Name (If not institution, g				4b. City, Town, or I		4c. County of De		
		Frederick Mem			hdevi If Under 1 Year	Freder:		Freder		
	Funeral Director	212-96-6215	Sex 7. Ag	ge (In yrs. last birt	Months Days		8. Dete of Birth (Month, Day July 25	, 1964 Ma	irthplace (State or Foreign Country) ryland	
ylend	wor.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits	
e Mar	ctor ctor	Maryland Fred	erick		Fr	rederick			1 Yes 2 No	
th th	or 28a-f e be notified Director	10e. Street and Number			10f. Zip Code	101	1	0g. Citizen of What		
ath w		9510 Bellhaven (217			U.S.A.		
.0020 hours after death with the Marylend	Lamber by Fun	11. Meritel Stetus 1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2X If Yes, Giva Yeer or Dates:		13. Was Decedent of If Yes, specify Cub		pecity Yes or No- o Rican, etc.)	Black, Wi	nerican Indian, nite, etc. White	
5-0 72 ho	deal Exp	15. Decedent's (Specify only highest of		16a.	Decedent's Usual Occu (Giva kind of work done	pation during most of wor	kina	16b. Kind of Busines	ss/Industry	
vithin	than than complete	Elementary/Secondary (0-12)	College (1-4or	5+)	(Giva kind of work done life. DO NOT use retire Courier	ed)	N	Courier S Laborator		
nd 2	d other avent, Be C	17. Father's Name (First, Middle, La						Maiden Sumama)		
Maryland	Marked marked	Rodney	W.		BOSLEY Verna EVANS					
lar 2 sh	la III	19a. Informant's Name/Raiationship			Mailing Addrass (Stree					
2 6	Health m 27 ther t	Brian A. Matting	gly, Brother					Laytonsv.	ille, MD 2088	
NOT Sego	or of the	1 ☐ Burial 2 X Cremation 3			Disposition (Name of y, crematory or other pla					
Baltimore	ortant: Injury B.	4 Donation 5 Other (Spec		Smiths	22. Name and Addr		15, 1990	Smithsbu	rg, Maryland	
Ba	Impo eny l	21. Signeture of Funeral Service Lic	21 10	1400700	Keeney & 106 East		.A. Fune	ral Home		
		230 Bort Enter the disease or so		MOO7O3	106 East	Church St	reet, Fr	ederick,	MD 21/01 Approximate	
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	ly one cause	na.	of enter the mode of dy	ing, such as cardia	or respiratory arr	est,	Intarval Between Onset and Death	
	ysiclan Medical	Immediate Cause (Final	T	3					1 . 4	
Ex	caminer	disease or condition resulting in deeth)	e	18419		ath			minute	
-	ě		13	Due to (or as a d	terms on.	Parala	-01/1	· Section	4/our	
cuted	physicien and s the burial-transit	Sequentially list conditions.	b	Dup to (or as e o	consequence off:	Leveer	al lo	Farcire	or Hage 4days	
0,00		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants	4	Lynna	Lycenca	1501	walten	oid Heur	or boar 4day	
68760, ifficete be execu	physicie is the bur edical	that initiated avants resulting in death) Lest	c	Due to (or as a	opsaquence of):					
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O. Box	ed by the ettendin detached for use. Physician/M		<u> </u>				J &	PODLOAG	1 4/-	
P.O. I	the e	Part II. Other significant conditions	contributing to death b	out not rasulting In	tha undarlying ceusa g	iven in Part I.	Paur Blan	special has contribu	ute to the causs of death?	
م ق	ed by detac				/\	MU	Fical	## 20No 3	Probably 4 Unknown	
ords, P	d by P				11	No Ce	CVz4a, Was	an autopsy 24	b. Wera autopsy findings	
	should should					redical 7a	Cal perfor	med?	available prior to completion of cause of death?	
I Rec	page 2 should				7	Medical Zai Andrew M Deputy 26. Piaca of Do	miner	es 2XNo	1 Yes 2 No	
= F	certificate rector, pag	25. Was case referred to medical				Deput Ex	ath (Check only o	es 200,00	TO Fes 20 No	
of Vita	=	examiner?	Hospital: Inpati	ent 2□ FR/Ou		ther		ence 6 Other (S	necify)	
Phys of		27. Manner of Death	28a. Date of Inju	iry 28b. T	ime of 28c. Inju		1	ow Injury occurred	1 1	
Vision	ath. e funer ation	1 Natural 5 Panding 2 Accident Investigat	ion (Month, De	98 3		Yes 2 No	Self	Injecte	d 4000 Insu	
	rs effer deeth. •I Diractor: Affer t led in by the funera Certification:	3 Suicide 6 Could not datarmine	28a. Place of in	jury - At home, faic. (Specify)	rm, straet, factory, office	, /	28f. Location (S City or Tow		Rural Routa Number, Bollharen CF	
	Ce Die	Home Frederik Maryland								
Di the Hospital or	within 24 hours effer deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	(Check only 2 Medical Ex	aminar: On the basis of	f examination and	, daath occurred at tha t d/or investigation, in my			ause(s) and mannar	as stated	
eg c	ithin 2 orthe ormple	one) 29b. Signature and title of certifier (and manner st	ated.	29c. Licer	on, In my opinion, death occurred at tha time, data and place, and due to the ceuse(s) 29c. License number 29d. Date signed (Month, Day, Year)				
7	≥ <u> </u>	(1) (1)	Val	11/7	77-	7710-	7	0 11	690	
		30. Name and address of person wh	o completed source of	tanth (ltam 23c)	Tuno Print)	2/17		6-17	10	
		Alan Rohr		10 Q1) 1	Defini	154	Fra.	levick	MD 21703	
		I wan Nun	or pure	10000	No IMPIC	V''	0 4 00	4	0110	

Registrar

Landon Committee of the second

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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1164 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Rydell BOWENS Jure 1815 TERRANCE 1998 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street and number) HOPKINS Battimore City Baltimore THE JOHNS HOSPITAL If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey. 5. Sociel Security Number If Under 1 Year Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Deys 1 X M 2 □ F Yrs. 1989 Frederick MD 215-23-4332 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Frederick Knoxville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe USA 1514 Jefferson Pike 21758 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2√€ No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Elementary School Student 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Lanny Herman Bowens, II Crystal Lynne Johnson 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Lanny H. Bowens 88 B East South St. Frederick MD 21701 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 □ Buriai 2 □ Cremation 3 □ Removal from State Sunnyside United Methodist Jefferson, MD Church of emethody of Focusion, John T. Williams Funeral Home Owner 100 Petersville Rd Brunswick MD 21716 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fugeral Service Licentee Williams, Banbana 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Brain Traumana twenty hours Injury Due to (or es e consequenca of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Lest Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobacco usa contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 XYes 1 Yas 2 No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1) Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 28d. Describe how Injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wed call Extended matt be not the page.

Baltimore, Maryland 21215-0020

physician and the burial-transit attending pl s certificate has b director, page 2 s

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Attending Physician: Aftarthis funeral after death. Director: Aft filled in by 6 24 hours To the Vithin 2

Physician/Medical p Be To Certification:

Examiner

3 Suicide 4 Homicide 29e. Certifier (Check only one)

1 Neturel

2 Accident

investigation 6 Could not be determined

5 Pending

28e. Dete of Injury (Month, Dey Year) June 11, 1998

2000 28e. Piaca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

MKnown

28b. Time of injury

59

28c. Injury at Work?

1 Yes 2 No

mD

Hit by Cax

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

21287-9106

29b. Signature end title of certifier

29c. License number 51551

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end placa, end due to the cause(s) end menner stated.

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

29d. Date signed (Month, Dey, Year)

Thre 12, 1998

Klum M Jouhaus 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 600 N. Wolfe Buttmore,

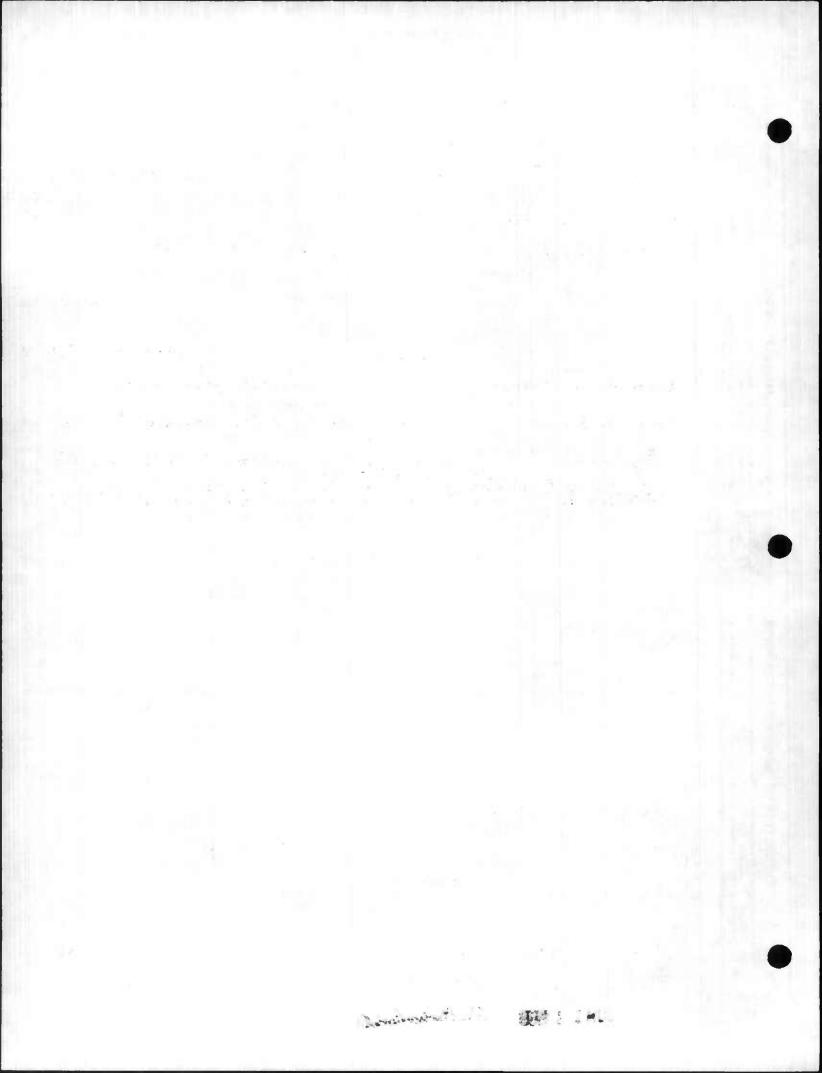
Johns Hospital Hospital 31. Dete filed (Month, Dey, Year)

JUN1

32. Registrer's Signeture this Blickon Roll

State Registrar

edicai



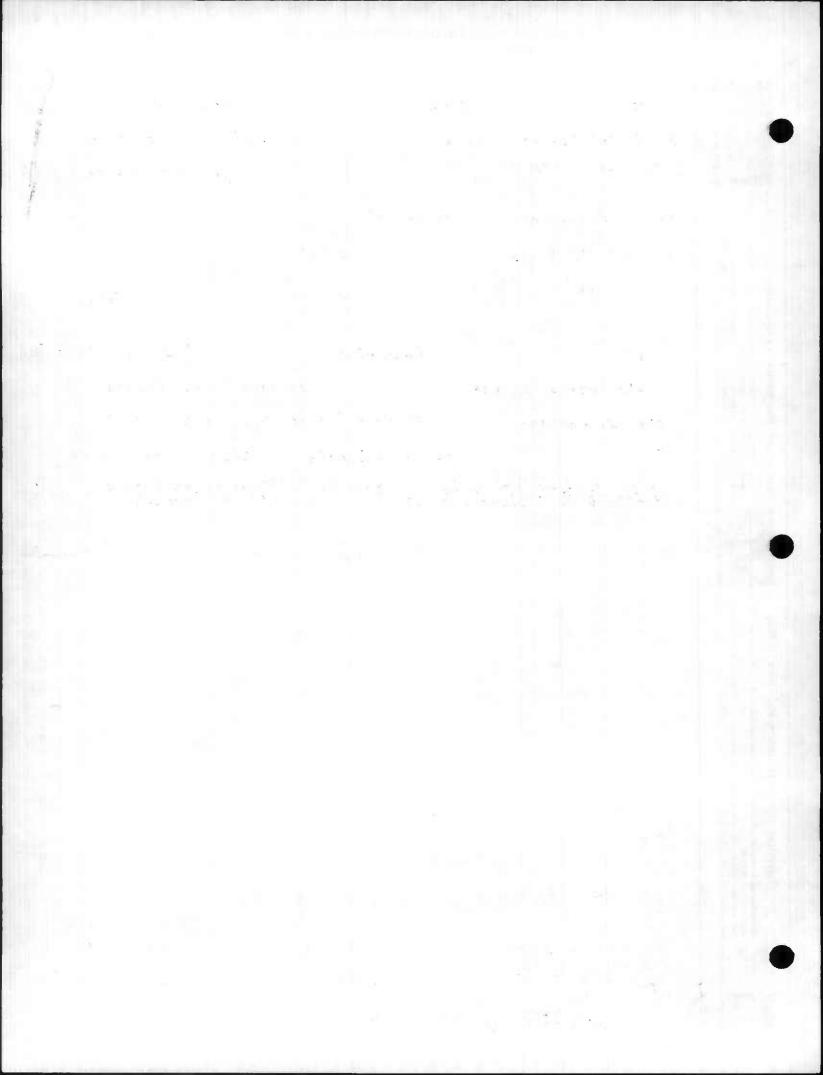
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 18, 1998 **Physician** Mark Douglas Brawner 2:25 P.M. /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 5. Social Security Number 217-58-4148 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 6. Sex **Funeral** XXM 2 F Months Deys Hours Min. Yrs. Apr 6 1952 Frederick MD Director Usual Residence of Decedent the Marylend 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylen Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any Injury or other than many Injury or other traumatic event, the Manical Estimins must be notified at any Injury or other traumatic event, the Manical Estimins must be notified at 1 Yes 2 No Frederick Director Brunswick Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 West "E" Street USA 21716 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status Black, White, etc. 1 Never Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Brunswick High Sch Custodian 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Dennis Eugene Brawner Delones Elaine Conner To 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 17 West "E" St. Brunswick MD 21716 Debra D. Brawner 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Reformed Cemetery 6/22 Knoxville, MD 4 Donation 5 Oyfer (Specify) 22. Name and Address of Facility
John 1. Williams Funeral Home
100 Petersville Rd Brunswick MD 21716 21. Signature of Funeral Service Licenses Banbana Williams, Owner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Finel disease or condition resulting in death) /Medicai Throw P Examiner Due to (or es e consequence of) Examiner physician and the buriel-tren Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or es a consequence of): requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, **Physician/Medical** Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? signed by the 1 Yes 2 No 3 Probably 4 →Onknown by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Be 25. Wes case referred to medicel exeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 12 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of antitier 29d. Date signed (Month, Day, Year) 29c. License number 021648 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 310 w 9th street Folich MD 21701 BARAKAT Lusan 32. Registrar's Signeture 31. Dete filed (Month, Dey, Year) State in Davidson Ros Registrar

DHMH 16 Rev 6/95



BADGLEY

State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle 1 ast) 2. Date of Death 3. Time of Death

Day

1998

4c. County of Death

0442AM

26,

Month

JUNE

4b. City, Town, or Location of Death

Physician /Medical **Examiner**

VICTORIA

LUCILLE

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

SURANA, M.D.

DEALE

Jalia Davidson-Randall

32. Registra 's Signature

MARYLAND

20751

C.

DR. GYAN

31. Date filed (Month, Day, Year)

4a. Facility Name (If not institution, give street and number)

CALVERT MEMORIAL HOSPITAL Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 79 Yrs. Birthplace (State or Foreign Country) **Funeral** 189-03-3423 1 M 2 F Months Yrs. Director August 15, 1918 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show the Medical Examiner must be notified at District Heights 1 Yes 2 No Prince Georges Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5 20747 United States 6515 Gateway Boulevard items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Merried 2 □ Married 21215-0020 8 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) 12 Personnel Clerk I.S. Government traumatic event, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Erminia Klivis Paul Katava 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Janice M. Al krittain 8418 Halsey RD, Lusby, MD 20657 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K2 Cremation 3 ☐ Removal from State Alexandria, VA 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematorium 21. Signature of Funerel Service Licansee 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island RD, Port Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Death Physician /Medical immediate Cause (Final HEMIPLEGIA days. disease or condition resulting in death) **Examiner** Examiner ACCIDENT EREBRO VASCULAR The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and bunial-trar Box 68760. ed by the attending physician detached for use as the buris CEREBRAL THROMBOSIS & INFARCTION Physician/Medical more than HYPERTENSION 10 years. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of deeth? signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RENAL FAILURE Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? POLYCYSTIC KIDNEY DISEASE completion of cause of death? certificate hes 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No Minpetient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Dascribe how injury occurred After t Natural 5 Pending Investigation after death.

Director: Af

d in by the fu death. 1 Tyes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled Certifying Phyelcien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. Medical 29a. Certifier 29b. Signeture end-title of cartifier 29d. Date signed (Month, Day, Year) 29c. License number Rvana. ran chand JUNE-26-1998.

State

Registrar

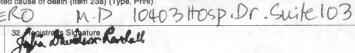
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4.8 **Physician** - 11 DM HENRY Darber 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4. Facility Name (If not institution, give streetland number) Haspital 7503 Scrall Road **Examiner** Prince CHINTON JEORGE If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Min. 10€M 2□ F Yrs **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ehow traumetic event, the Medical Examinar must be notified at 1 Yes 2 No Directo MD 10g. Citizen of What Country? 10e. Street and Number 748 death y Funeral 1010 Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus Black, White, etc. permit. Peges 1 and 2 should be filled within 72 hours after Department of Heelth and Mantel Hygiana. TX Yes 2 □ No If Yes, Give Year or Dates ARM Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Black þ 3 Widowed 4 Divorcad Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working
life, DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Posta Mail sarrier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ANNIE SAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Important: If tem 27 is any injury or other traun JED R919 30273 3043 Watter ex, CI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 30253 20e. Method of Disposition Date 18 Buriat 2 Cremetion 3 Removal from State 6-25.48 Mª Donough, GA tone rel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Forercal Services 21. Signature of Funeral Servica Licansee 23a. Part1. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20002 Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical sespirator **Examiner** Examiner attending physician and for use as the bunal-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Advance Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of 23b. Did tobacco use contributs to the cause of death? signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed certificate hes b lirector, pege 2 sl 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 28. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑Natural 28d. Describe how Injury occurred 28b. Time of 28c. tnjury et Work? Certification: 5 Pending investigation After 1 Yes 2 No Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rurat Route Number, City or Town, State) a Funeral Direct bletely filled in by 6 4 Homicide Hospital edicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 120052023

31. Dete filed (Month, Day, Year) Registrar

JUN 26 1998

MARIA

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)



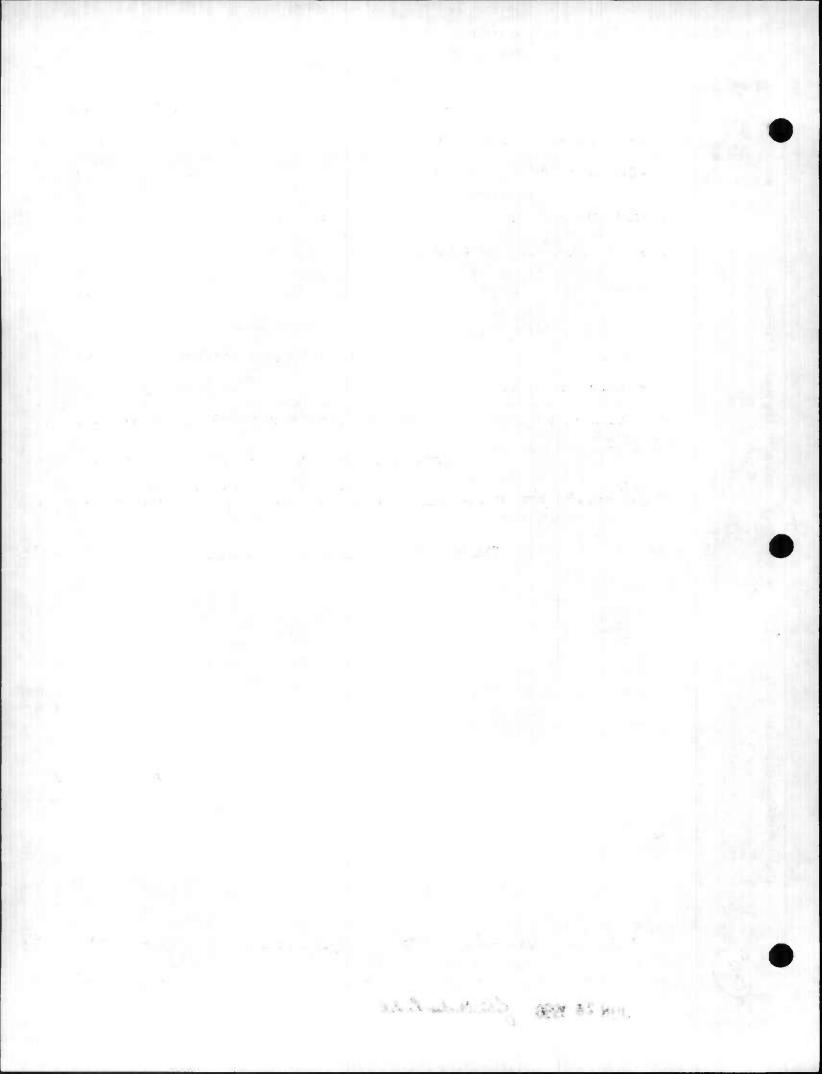
TOTAL STORAGE TOTAL STORAGE

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State of Maryland / Department of Health and Mental Hygiene 98

						Ce	ertifica	te of	Death			Reg. No.			50
	D1 -1-1-	_	1. Decedent's Name (First, Middle,	Last)					0.0		2. Dete of De Month	ath Day	Yeer	3. Time o	of Death
	Physiciar /Medica		Earl C		Brow	wn				J		4, 199		9:45	PM
	Examine		4e Fecility Name (If not institution,					4	4b. City, To	wn, or Loc	ation of Deat	4c. County	of Death		
			2199 Matthew	Henson	Aver	nue				ando		Princ			
	Funeral		Marine Manager and American	Sex 7		. lest birthday	Months	er 1 Year Days	Hours	Min.	6. Date of Bir (Month, De	th y, Yeer)	9. Birthp	plece (State ntry)	or Foreign
٠	Director		223-58-1348	ALAW ZLIF	52	2 Yrs.]]]	April 4	4, 1946	V:	irgin	ia
	pur *	-	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or I	Location							10d. tnside (City Limits
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	death w	6	11. Marital Status	12. Was Deced			Was Dec	edent of H			cify Yes or No	14. Rec		can Indian,	
	ter dea	5	1 Never Married 2 Married	Armed Ford	ces?	,,,,,	If Yes, sp	ecify Cuba	an, Mexican	n, Puerto P	cify Yes or No lican, etc.)	Ble	ck, White,		
320	0 0	2	3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Yeer or Del	les:		1 ☐ Yes	ZZ No	Specify:			Specify	/: B1	lack	
21215-0020	naturel'		15. Decedent's	Education		16a. Dec	edent's Us	uel Occup	pation			16b. Kind of B	usiness/in	dustry	
215	hin 7	Completed	(Specify only highest (Elementary/Secondary (0-12)	grade completed) College (1-	40r 54)	(Giv	DO NOT	vork done use retired	during most d)	it of workin	9				
21	d withir giene. rr than	ē	12th	College (1	401 34)	Custo	mer S	Servi	ce Re	prese	entativ	re P	riva	ate	
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/a	D = 0 -	0	Willie Sco	tt Brow	n						Mary	Crump			
Maryland	s 1 and 2 should I Health and Men tem 27 is marke other treumatic		19e. Informant's Name/Reletionship									er, City or Town,			
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ore	permit. Pages 1 Department of He important: If then eny injury or oth DDCs.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□Removal from S	20b.	Place of Disposer cometery, cr	position (N emetory or	ame of other plea	ce)		Date	20c. Location	· City or To	own, State	
E			4 □ Donetion 5 □ Other (Spe			esapea	ke Cı	emat	ory	6/	/26/98	Beltsv	rille	, Mary	yland
Baltimore,			21. Signeture of Funeral Service Lic	ensee			22. Name	end Addre	ss of Facilit	ne F	unera	1 Home	11-7-1		
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			23a. Part1. Enter the diseese, or co	emplications that can	used the dee	eth. Do not e								Approxima Interval Be	ate
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1			resulting in death)	v .	Due to	(or es a cons									
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×	ding ise as	N.W.		d									1		
8	that the death of the attendetached for u	rinysicial													44.40
P.O.	the d	3	Part II. Other significant conditions	contributing to dea	ith but not re	sulting in the	underlying	cause giv	ven in Part I	l.		tobacco usa co	3 Pro		Unknown
	that the ned by the detach										,,,	Yas 2□ No	3 - 10	Dauly 4)	gonknown
Division of Vital Records,	The law requires that it as has been signed by page 2 should be detac	2									24a. Was	an autopsy	24b. W	ere autopsy	findings
00	short s	2									perfe	ormed?	CC	vailable prior ompletion of death?	
Re	The law ate has be page 2 s										10	V 01/V-	1 1 1 1		Man.
e	certificate rector, pag		25. Was case referred to medical						00.81				1 ''	☐ Yes 2	No
5	Physicien: this certific ral director,	0	examiner?	Hospital:	nationt OF	☐ ER/Outpati	ent 3 🗆 [Oth	ner.		(Check only		har /Chas	16.41	
of	4 5 6		27. Manner of Death	28a. Date of		28b. Time		28c. Injur		ursing Horr		how injury occur	her <i>(Speci</i> rred	ny)	
On	ding th. Afte	5	1 Selatural 5 Pending investigat		, Dey Year)	Injury	М		rk? ∣Yes 2.⊟	No					
/Si	Attending or death.	2	3 ☐ Sulcide 6 ☐ Could not	be 28e. Place o	of Injury - At I	home, ferm, s	street, fecto	ory, office		2	8f. Location	Street end Numi	ber or Rur	rel Route Nu	m <i>ber</i> ,
Ö	tal or Attending P rs after death. al Director: After the in by the funera	5	4 Homicide	building	g, etc. (Spec	ify)					City or To	wn, State)			
	Hospital 24 hours Funeral stely filled	5	29a. Certifier 1 Certifying	Physician: To the b	est of my kn	owledge, dea	ath occurre	d at the tir	me, date an	nd place, a	nd due to the	cause(s) end m	enner as s	stated.	
	To the Hospital or Attending Phywithin 24 hours after death. To the Funetal Director: After thi completely filled in by the funeral Macallesi Cereilland	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 medical Examinarian at the control of the c								ath occurre	d at the time,	date and place,	and due t	the cause	(s)
	within 2 To the		29b. Signature and title of certifier	11	^		2	9c. Licens	e number			29d. Date signe			
			Milleloule	1 Koula	she,	MD		04	f670	14		Ton	2	5,1	448
	10)		30. Name and address of person wh	o completed cause	of death (Ite	m 23a) (Type				0		0		5,1 1-AR	-
	(0)		MUTOMBO	KAN KO	NDE		KAZ	8C 6	2	ren	- Man	CNTE	-	LAR	50
	State	,	31. Date filed (Month, Day, Year)	32/70	gistor's Sign	neture	M								
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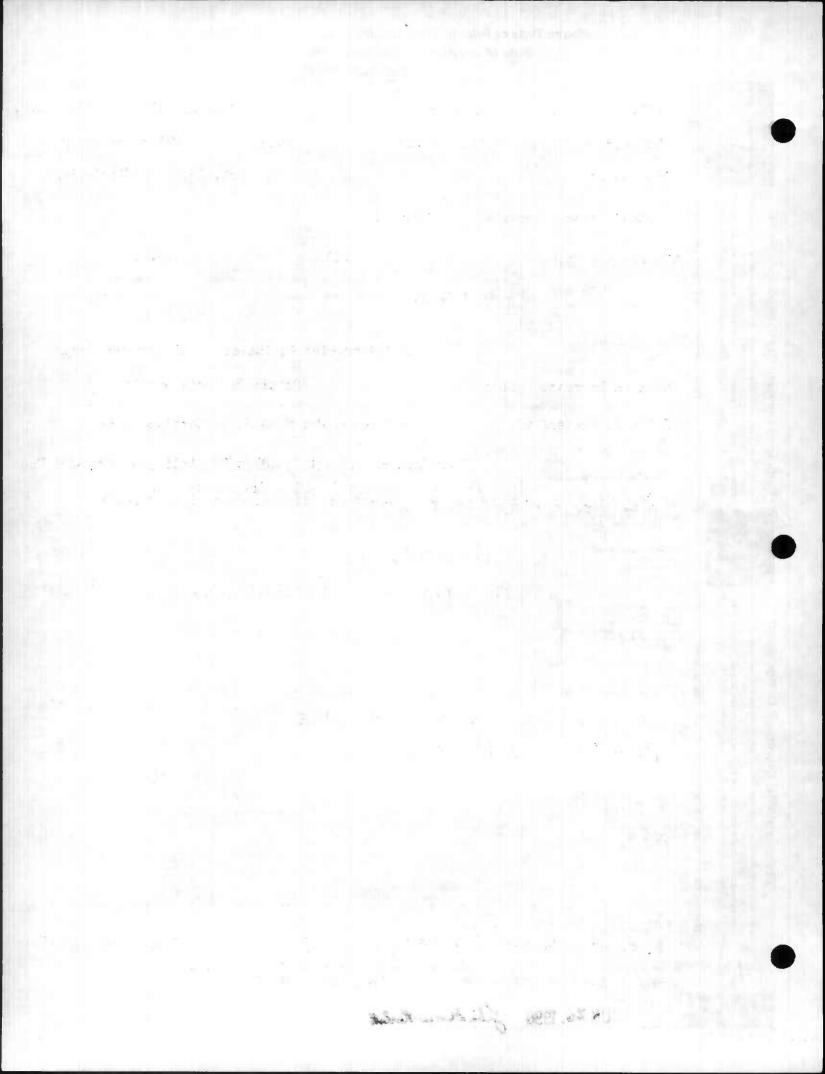
Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** June 23, 1998 William 10:00 A.M. Α. Butler /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Clinton Prince George's Southern Maryland Hospital Center If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 20 F Months Days Hours Min Yrs Director Oct. 25,1910 546-34-3383 Mississippi Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiana. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show way injury or other traumstic event, the Mazica Examinal must be notified another. 10d. inside City Limits 10e State 10b County 10c. City. Town or Location 1 Yes 2 No Maryland Prince George's Oxon Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20745 U.S.A. 900 Lindsav Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? NOTYes 2□ No If Yes, Give 1937–52 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant U.S.Marine Corps. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Hattie Pernecia Herring William Lawrence Butler 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Pnint) Ellie J. Butler/Wife 900 Lindsay Rd. Oxon Hill, Maryland 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burlai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 7/6/98 Arlington Virginia 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md.20745 OLOU UXON HILL Rd. OXON HILL Section of the complex Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner PNEUMONIA ATERAL certificate be axecuted attanding physician and for usa as the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): The law requires that the death P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 1 Yes 2 No 3 Probably 4 Unknown yd bengis HEART FALLURE ρ 8 24b. Were autopsy findings available prior to completion of cause of death? sata has been signed and a should be 24a. Wes an autopsy performed? Completed RENAL FAILURE 2 No 1 Yes 1 Yes 2 No cartificata Division of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: P 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Hospital or Attending Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edical nolately (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 50653 JUNE 23 - 1998 Gyan C. Surana, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUKRATTS ROAD. CLINTON. 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State JUN 26. Jelia Mudeen Rea Registra

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21070

					Certificate	of Death		Reg. No.		
	1. Decedent's Nama (First, A	fiddle, Last)					2. Data of D	eath	3. Time of Death	
Physician	Virginia	ee Be	ckett				June	Day 18. 199	98 8:03 pm	
/Medica Examine	An Panilibu blown III and innel	ution, give stre	eet and number)			4b. City, Town	, or Location of Dea			
A)	Prince Geor	ge's He	ospital	Center		Cheve	rly	Prince	e George's	
Funeral	5. Social Sacurity Number	6. Sax		(In yrs. last bil	Months E		Hrs. 8. Date of B	irth	Birthplace (State or Foreign Country)	
Director	578-18-8572 Usuai Residenca of Deceder		1 2X) F	81	Yrs.	,		4, 1916	Washington, DC	
how	10a. State 10b. Co	unty		10c. City, Tow	n or Location				10d. Inside City Limits	
the Me	Maryland Pri	nce Ge	orge's	Fore	stville 10f. Zip Co	ode		10g. Citizen of V	1 No Yes 2 No What Country?	
Sa o se	2605 Overdal	e Place	2			20747	1.4	U.S.	Α.	
me 2	2605 Overdal 11. Marital Status 1 Never Married 2		Was Decedant E	var in U,S.			? (Specify Yes or Note of Note		e - American Indian,	
020 urs a	3 ₩idowed 4 □ Divo		Armed Forcas? 1 ☐ Yes 2 N If Yas, Give Yaar or Datas:	0	1 ☐ Yes 2 🖔		ueno Hican, aic.)	Specify	k, White, etc. White	
2 ho	15. Dece	dent's Educat		16a	. Decedent's Usual C	occupation		16b. Kind of Bu	usiness/Industry	
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21 21 ad will be the structure of the st	12				Secretary			Federal Govern		
nd in the second	17. Father's Name (First, Mid	ldle, Last)				18. Mother's	Name (First, Middl	e, Maidan Sumam	na)	
laryland 212 2 should be filed withi and Mental hygiene, is marked other than summit: event, the u	Laurence C.	Merc	hant			Marga	aret M.	Malone		
Aar 2 shot and is mu	19a. Informant's Name/Rala	ionship (Type,	, Print)		o. Mailing Addrass (5					
Health Health em 27	Donna J. Sla	ttery -	- Daughte		03 Overda			T		
0 00-	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramat 4 ☐ Donation 5 ☐ Other		novai from Stata	cemete	f Disposition (Name ry, crematory or othe ODOIItan (r place)	Date 6/23/98		City or Town, Stata	
Baltimoperant: Peg Department important: Heary injury o	T. Signature of Funeral Say	vice Licensee	()	A	22. Name and A	Addrass of Facility Funeral H				
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Physician	snock, or naart failure.	Life only ona	cause on each lin						Interval Batween Onsat and Death	
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O. the od with a scheen	Part It. Other significant con	ditions contri	buting to death bu	t not resulting i	n the underlying cau	se givan in Part I.			3 Probably 4 Unknown	
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	o passiduo							s an autopsy formed?	24b. Were autopsy findings available prior to completion of cause	
0 8 80								,	of death?	
- F 50 (1	Yas 2 No	1 ☐ Yes 2 ☐ No	
Of Vital Physician: The rthis certificata ral director, page			nitei.				Death (Check only	one)		
Physic Physic ruthis or all directions or all di			pital:			1	ng Home 5 ☐ Ra			
E 5 5 5	27. Manner of Death 1 Natural 5 Pe 2 Accident Inv	restigation	28a. Date of Injury (Month, Day Year) 28b. Time of Solution 1 28c. Injury at Work? 1 Yes 2 No				how injury occur	red		
Division or Attending after death. Director: After d in by the fune	3 Suicida 6 Co	euld not be remined	28a. Place of Inju building, etc	ry - At homa, fa . (Specify)	arm, streat, factory, c	ffica	28f. Location City or T	(Street and Numb own, Stata)	per or Rural Route Number,	
he Hospi in 24 hou he Funar pletaly fil	29a. Certifier (Check only one) 1 Certifying Phyatclan: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) 2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at tha tima, data and and manner stated.									
To the To the Com	29b. Signature and title of certifiar 29c. Licansa number							29d. Data signe	d (Month, Day, Year)	
C-	Her	yaca	Tel	11	DO	9451		June 1	9, 1998	
(10)	30. Name and address of per Benjamin S.				(Type, Print)		11 Road		11e, MD 20747	
State	31. Data filed (Month, Day, Y	ear)	32 Benistra	r's Signature		ZZVCI III.	rr noau,	FOLESTAL	11e, FID 20/4/	
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State of Maryland / Department of Health and Mental Hygiene 2 | 0 7

Certificate of Death

Reg. No.

			Ce	ertificate c	of Death		Reg. No.	
Physician /Medical	Decedent's Neme (First, Middle, L. A I SHA	BIBI	1.4			2. Dete of D Month JUN	eath Day	3. Time of Death
aminer		MUNITY H	OSPITAL		LANH	or Location of Dee	oth 4c. County PRINC	of Death E GEORGES
eral tor		Sex 7. Age (I 1 □ M 2 □ F 68	n yrs. last birthdaj Yrs.	Months Da		8. Dete of B (Month, D 9-3-2	Pav. Year)	9. Birthplece (State or Foreig Country) Pakistan
irector	10e. Stete 10b. County	e George	Bowie	Location				10d. Inside City Limit
Funeral Director	10e. Street end Number 4659 Running Dee	er Way		10f. Zip Cod 2072			10g. Citizen of the Pakist	
by	11. Maritel Stetus 1 Never Merried 2 Morried 3 Widowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	or in U,S. 13	Wes Decedent of It Yes, specify C	of Hispenic Origin? Suben, Mexican, Pu No Specify:	(Specify Yes or Nierto Rican, etc.)	Bla	e - Amarican Indien, ok, White, etc. Y: Pakistani
Be Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Giv	edent's Usuel Oc re kind of work do DO NOT use re OUSEWIF	ne during most of tired)	working	16b. Kind of B	usiness/Industry
To Be C	17. Father's Neme (First, Middle, Las Satah Mohammad)			18. Mother's Fazal	Verne (First, Middl Jan	e, Maiden Surnan	ne)
traumatic To	19e. Informent's Neme/Reletionship Mohammad Shafic			_	eet and Number or Deer Wa			
other	20e. Method of Disposition 1X Burial 2 Cremetion 3 [4 Donetion 5 Other (Spec	Removel from State	20b, Pleca of Dis	position (Name of ematory or other		Dete	20c. Location	City or Town, State ndi, Pakistan
any injury or or on one	21 Signature of Funerel Servica Lica	nsee Moto			dress of Fecility U			
Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	e to (or es e cons e to (or es e cons e to (or es e cons	equenca of):				
Physician	Part II. Other significant conditions	dcontributing to death but n	ot resulting in the	underlying cause	given in Part I.		d tobacco usa co ⊇Yes 2□ No	ontribute to the cause of deal
Completed by						24e. We	es en eutopsy formed?	24b. Were autopsy findings evailable prior to completion of cause of death?
						10	Yes 2 No	1 ☐ Yes 2 ☐ No
I director	25. Was case referred to medical exeminer? 1 Yes 2 No	Hospital:	2 ER/Outpet	ent 3 DOA	Other	Deeth <i>(Check only</i> g Home 5 Re		ner (Sneciki)
	27. Menner of Deeth 1 Netural 5 Pending 2 Accident Investigation	28e. Dete of Injury (Month, Day Y	28b. Time	of 28c. I	njury et Work? 1 Yes 2 No		e how injury occur	
al Director: After the in by the funeri led in by the funeri Certification:	3 Suicide 6 Could not determined	28e. Place of Injury building, etc. (- At home, ferm, s Specify)	street, factory, off	ica		(Street and Num. own, State)	ber or Rural Route Number,
Fune dicai		nysicien: To the best of miner: On the basis of ex and manner stated	aminetion end/or					
Mec	296. Signature and little of certifier	(1800)	J en	29c. Lic	ense number	777		ed (Month, Day, Year)
	30. Name and address of person who	completed cause of deet	h (Item 23e) (Typ MD 300	o, Print) OI HOSPI	TAL DRI	VE, CHE		MKYLAND 2078

State Registrar

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State of Maryland / Department of Health and Mental Hygiene 0 0 1072

						, , , , , ,	C	ertificat	e of			Reg. No.	6-	0 1	4
		_	1. Decedent's Nem	e (First, Middla, La	ist)						2. Dete of De Month	ath	Yaar	3. Time	e of Death
ı	Physiciar /Medica		James		Bell							Day 18 199		7:0	OOA.M.
	Examine		4a Facility Neme (If not institution, giv	a street and numbe	r)				4b. City, Town, or L		4c. County	of Death		
					orest Driv					Silver S	pring	Montg	omer	у	
	Funeral		5. Social Sacurity N		Sex 7. A 1 23 M 2 □ F	ge (In yrs.	last birthda	Months	1 Year Days	Hours Min.	8. Date of Bird (Month, Da	th y, Year)	9. Birthic	lece (Sta	ta or Foraign
	Director		577-32-9 Usual Residence of	722	2011	67	Yrs.				Nov. 26	1930	Wash	ingto	on, DC
	and wa	-	10a. State	10b. County		10c. Cit	ty. Town or	Location					1	0d. Inside	City Limits
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	or 28s-f s	9	10e. Street and Nu		zı y	٥	TTAGE	10f. Zip				10g. Citizen of V	What Cour	ntry?	
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pu	### E	9	17. Father's Name	(First, Middla, Last,)					18. Mother's Nen	ne (First, Middla,	Meldan Sumen	10)		
Maryland		0	Leroy Ba								de Thoma				
Mai	2 8 8 8			eme/Reletionship (Type, Print)					t and Numbar or Ru					
	1 and 2 Health em 27 i	-	Lois Be			20b F	1330 Place of Dis	08 She sposition (Na	TWO C	od Forest	Dr. Si	Llver Sp			
Jou	Se to L		1 □ Burial 2	☑Cremation 3 □	Removal from Stat	a	camatary, c	remetory or o	thar pla						
Baltimore,	it. Purtue	-		5 ☐ Other (Special Service Lice)		M	etrop			ematory			ria,	VA.	
Ba	permit. Pag Department Important: any injury o		M /	m	10			Marsh	all	s Funera	1 Home,	Inc.			
-	_	+	22a Deat Enter	-///au	plicetions thet caus	ad the deal	th. Do not a			th St. NW			C 20	O11, Approxis	mate
	Dhusisian		shock, or hea	irt failure. List only	one cause on each	line.	in. Do not t	enter the anot	o or ayı	ng, such as cardiac	or respiretory o	11001,	- 1	Interval	Between nd Death
	Physician /Medical		Immediate Cause	(Finel	0 14										
	Examiner		diseasa or condition resulting in death)	on	a. Cardia			sequence of):					+1	ninut	es
	D #				Due to (or es e consequence of): Acute Cardiac Dysrhymia						minutes		tes		
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Box	death cert e attending ed for use	lan											1		
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0	that the ded by deta										10	Yee 2 No	3 Pro	DEDIY 4	Unknown
Records,		o D										en autopsy			sy findings
00	w requir	completed									perio	ormed?	00	allable promplation death?	of causa
	The law ate has page 2										10	Yes 2XNo		□Yes	2□ No
of Vital		D I	25. Wes case refer	rred to medical						26. Place of Dec			1		
2			exeminer?	No	Hospital:	tient 2	ER/Outpet	tient 3 D	OA Ot	hor:		denca 6 □Ott	ner (Specia	(y)	
	g Physical distriction		27. Menner of Deet		28e. Dete of In	jury Jav Yaar)	28b. Time	e of	8c. Inju	ry at	28d. Describe	how Injury occur	red		
ioi	Attending I r death. actor: After by the funer	and	1 Matural 5 Pending (Month, Day Yaar) Injury Work? 2 Accident Investigation M 1 Yes						Yes 2 No						
Division	rs after death. al Director: After t ied in by the funera		3 ☐ Sulcida 4 ☐ Homlcide	6 Could not be determined	286. Place of I	njury - At h	ome, farm,	street, factor	y, offica		28f. Location (City or To	Straat and Numi wn, Stata)	ber or Run	al Routa I	Vumber,
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	ne Hosp n 24 hou ne Fune pletely fil	20	29a. Certifier (Check only one)		nysician: To the bes miner: On the basis	of examina									se(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ti		29b. Signetura and	title of certiflar	and menner	steted.		29	. Lican	sa number		29d. Data signe	ed (Month.	Day, Yes	ar)
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	(3)				m, M.D. 1				Mad	shington,	DC				
	State	,	31. Date filed (Mon			trer's Sign		D C • TAM	wai	JILLIE COIL,	50				

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						C	Certificate of	Death	Reg	g. No.	3 2	1070
		Physic	an	Decedent's Name (First, Middle, L.	ast)				2. Date of Death Month	Day	Year	3. Time of Death
		/Medi		Otis N. Byr					June		998	1:20PM
		Exami	ner	4a. Facility Name (If not institution, gi	es in entering			4b. City, Town, or Loc	eation of Death	4c. County		
	ŀ		-	Laurel Region 5. Social Security Number 6.		3. L. ge (In yrs. last birtho	fav) If Under 1 Year	Laurel		Princ		
		Funeral Director			10XM 2□ F	59 Yr	Months Davs	Hours Min.	8. Date of Birth (Month, Dey,) June 15	rear)	~	ce (Steta or Foreign
		_		Usual Residence of Decedent				1	Julie 13	1939	Geo	rgia
		show	_	10a. State 10b. County	Coomonia	10c. City, Town o					100	d. Inside City Limits
		Se-f	Director	Maryland Prince	George's		Land	over				N Yas 2 No
		with th	Dic	10e. Street and Number			10f. Zip Code		109	g. Citizen of W	Vhat Countr	y ?
2		s 23	Funeral	3303 Dodge Park	Road, #T-			0785	it. Vac as Na	_	ted S	tates
6		her d	Fun	11. Marital Status 1 ☐ Naver Married 2 ☒ Married	Armed Forces	?	If Yes, specify Cub	Hispanic Origin? (Spec ban, Mexican, Puerto F	Rican, etc.)		k, White, et	
2	020	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Yas 2√□ No	Specify:		Specify	Bla	.ck
-	21215-0020	72 ho	Completed	15. Decedent's E (Specify only highest gr		16a. D	ecedent's Usual Occu	pation during most of workin	16	Sb. Kind of Bu	isiness/Indu	istry
)	21	ithin and	nple	Elementary/Secondary (0-12)	College (1-4or	- li	fe. DO NOT use retire	ed)	9			
	7	iled w tygies ther th		9th 17. Fathar's Name (First, Middla, Las	AT .		Construc	tion Worke			rivat	e
	and	2 should be filed within 72 hours after death with the Maryland and Mental Hygiens. le marked other than "natural", or hams 23s or 28s-f show raumatic event, the Medical Examener must be notified at	Be	Arthur Lee				18. Mother's Name				
	Ž	shoul nd Me mark metion	L 2	19a. Informant'a Name/Relationship		19b. M	lailing Address /Stree	et end Number or Rure	Elizabet		-	Codel
0	×	alth are		Ellen Byrd - Wi				Park Road,				
330	J.	othe othe		20a. Method of Disposition		20b. Place of D	isposition (Neme of crematory or other ple			Oc. Location -		
143	E	Page nent int: If iry or		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		,	ny Memoria		/24/98	Land	over,	MD
	Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service Lice	nsee A		22. Nama and Addr		tewart F			
	0	89 5 5 8		I shu Ti	Stewar I	TIT	4001 Beni	ning Rd.,	N.E. Was	h., D.	C. 20	019
al	-			23a. Part 1 Enter the disaasa, or con shock, or heart failure. List only	pications that cause one cause on each li	d the death. Do not ine.	enter tha moda of dy	ing, such as cardiac or	respiratory arres	st,		Approximate interval Between
V		Physician				-1-11			100			Onset and Death
		/Medical Examiner		immediate Cause (Final disease or condition resulting In death)	a	HeBILO	PAS CULAR	1 INFI	AKCT		- 1	DAYS
			e	•		Due to (or as a cor	nsequence of):					
5		d d ansit	edicai Examiner	Sequentially list annothing	b. ———	Due to (or as a cor	readillance off:				i	
Byah	0	an an	Exs	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		500 10 (01 25 2 50)	isoqualios oij.				1	
R	68760,	icate be executed physician and s the burial-transit	Ilcai	that initiated events resulting in death) Last	c	Due to (or as a con	sequence of):					
		entific ling p	-		d							
	Box	aath certifi attending	Physician/M		U						1	
15	0	t the de by the tached	ysk	Part II. Other significant conditions	contributing to death b	out not resulting in th	e underlying cause gi	iven in Part I.				the cause of death?
7	Ω.	es that the igned by be detact		1)//	heres				1 T Yes	2 No	3 Proba	ibly 4 Donknown
0	rds	quires n sign	ed by	A	THAL,	FIROM	117700)		24a. Was an		24b. Wer	a autopsy findings
	00	sw requin	Completed		11-1110	PIJAO	CATION	-	performe	ed?	com	lable prior to plation of cause eath?
	R	The lew ate has page 2	mo						1 ☐ Yes	2 ILNO		Yas 2010
	ita	certificate	Be C	25. Was case referred to medical				26. Place of Death				
	>	hysicie ils cert	To	examiner? 1 Yes 2 1 No	Hospital:	ent 2□ER/Outpe	Stient 3LI DOA	her: 4 I Nursing Hom	e 5 Residen	ce 6 □Othe	er (Specify)	
	n	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Tim lnju	ry Wo		8d. Describe how	Injury occurr	ed	
	0	uttandi death. ctor: A y the f	cat	2 Accident investigation 3 Sulcide 6 Could not be	20			Yas 2 No	0(1 10 10			
	S			4 ☐ Homicide determined	building, et	jury - At home, farm ic. <i>(Specify)</i>	, street, factory, office	2	8f. Location (Stre City or Town,	Stete)	er or Hurai i	Houte Number,
	Divisi	or A aftar Direct	ertifi	4 - Mornicide								
	Division of Vital Records,	spital or Attand hours after death heral Director: , filled in by the	ai Certification:	29a. Certifier 1 Certifying Pt	hyaiclan: To the best	of my knowledge. d	eath occurred at the ti	ime, date and place as	nd due to the cau	ise(s) and ma	nner as stat	ted.
	Divisi	ne Hospital or A n 24 hours attar ne Funeral Direct bletely filled in by	edical Certifi	29a. Certifier 1 Certifying Pi	hyaician: To the best miner: On the basis o and manner st	f axamination and/o	eath occurred at the ti r Investigation, in my	ime, date and place, as opinion, death occurre	nd due to the cau d at the time, date	ise(s) and ma e and place, «	nner as statend due to t	ted. he cause(s)
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	Divisi	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in by	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Pr 2 ☐ Medical Exam 29b. Signature and title of certifier	miner: On the basis of and manner st	of axamination and/o	29c. Lican	opinion, death occurre sa number	d at the time, date	e and place, «	end due to t	he cause(s)

Physician /Medical	1	Decedent's Name (First, Mid FLORENCE LILI Facility Name (If not institut	IAN	BUONOC					lb. City, Tow	n orla	JUN JUN	of Death h E 16	Day 1998		3. Time of Death 5:00 P.1
Examiner	ľ	DOCTOR'S COM							LANHA		JOZION OF	Dout.			ORGE'S
Funeral Director		5. Social Security Number 092-54-8289	6. S			s. last birthday Yrs.	/) If Und Months	er 1 Year Days	If Under 24 Hours		8. Date (Moni MAR.	of Birth th, Day, Y		9. Birth	place (State or Foreigntry) YORK
		Usual Residence of Decedent 10a. State 10b. Coun		GEORGE'		City, Town or L									10d. inside City Limi 1 X Yes 2 □ N
off with the Ma 23s or 28s-fs		10e. Street and Number 22 RIDGE ROAD		301				ip Code 20770					o. Citizen of UNITEI) STA	TES
72 hours effer deeth with the Maryland naturel, or frems 23s or 28s-f show deal Example must be notified at the by Funeral Director	2	11. Marital Status 1 Never Married 2 Mi 3 X Widowed 4 Divorce		12. Was Dece Armed For 1 Tes If Yes, Giv Year or D	rces? 2⊠No ⁄e	U,S. 13.			lispanic Origi an, Mexican, Specify:	n? (Sp Puerto	ecify Yes Rican, et	or No- c.)		ck, White	ican Indian, , etc. ITE
1	Ompleted	15. Deceding (Specify only high Elementary/Secondary (0-12)	est gra	ducation ide completed) College (*	I-4or 5+)	(Give	edent's Us re kind of w DO NOT	vork done use retired	ation during most of	of work	ing	16	OWNEI	Business/Ir	
and Mental Hygiene. s marked other than aumatic event, the March To Re Comp	000	17. Father's Name (First, Middle WILLIAM DAVIS							ANNA	L.	STEI	NERT	aiden Sumai		
l and 2 si Health and am 27 is r ther traur		19a. Informant's Name/Relatio MARGARET A. SI				51-J	RID	GE RO	AD, GF			, MA		20	770
Pege nent o ury or		20a. Method of Disposition 1 □ Burlai 2 □ Cremation 4 □ Donation 5 □ Other 21. Signature of Funeral Service	(Specify	y)	SIMILE		NCOLN 22. Name	CEMI	ETERY		6/20/	98 E	BRENTW	00D,	MARYLAND
Physician // Medical examiner of public and interpretatif if Medical examiner		1 Burlai 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	(Specify	plications that cone cause on e	FOOW eused the de ach line.	ORT LIN	NCOLN 22. Name FORT 3401 Inter the me	CEMI and Addre LINCO BLADE ode of dyir	ETERY ss of Facility LN FUN NSBURG	NERA	6/20/ L HO	98 E ME RENT	WOOD,	MARY	
le be executed Ysician and By And Copartment of Strain and Important: If the build-transit any Injury or any Inj	Ical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	(Specify	plications that cone cause on e	eused the de each line. ARDIAL Due to	ORT LIN	NCOLN 22. Name FORT 3401 3401 Inter the mo	CEMI and Addre LINCO BLADE ode of dyir	ETERY ss of Facility LN FUN NSBURG	NERA	6/20/ L HO	98 E ME RENT	WOOD,	MARY	I.AND 2072 Approximate Interval Between Onset and Death
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Les law requires that the deem certificate be executed to be an importment of a bage 2 should be detached for use as the bunal-transit of an important: If a bage 2 should be detached for use as the bunal-transit of any Injury or completed by Physician/Medical Examiner	by righted medical Examinist	23a. Part1. Enter the disease, shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Part II. Other significant conditions.	(Specify Committee License Com	b c c c c c c c c c c	eused the de lach line. ARDIAL Due to Due to	ORT LIN grath. Do not er INFARC (or as a consection of the cons	NCOLN 22. Name FORT 3401 3401 Inter the more CTION equence of	CEMI and Addre LINCO BLADE toode of dyir f): f):	ETERY ss of Facility LN FUN NSBURG ng, such as c	NERA	6/20/ AL HO Do., B or respira	ME RENT tory arres	WOOD,	MARY ontribute 3 □ Pro 24b. V	I.AND 2072 Approximate Interval Between Onset and Death 2 HOURS to the cause of dea obably 4 Unknown Vere autopsy finding valiable prior to ompletion of cause
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1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

D17572 JUNE 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID S. GRANITE, M.D., 115 CENTERWAY, GREENBELT, MARYLAND 31. Date filed (Month, Dey, Year)
JUN 23 1998

State Registrar

29b. Signature and title of certifier



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Please	Type or Print in I State of Marylar	nd / Dep		f Health and	Mental Hygi		ble. 3 21075
1. Decedant's Nama (First, Middla, La	st)				2. Data of Death	1	3. Tima of Death
STEPHEN N. BRIS	COE				Month	Day	Yaar
4a. Fscility Nama (If not Institution, give	a straat and number)			4b. City, Town, o	TUNE 21,	1998 4c. County	of Death
WASHINGTON ADVE	ENTIST HOSPITA	L		TAKOMA		MONTG	OMERY
5. Social Security Number 6. S 577-52-9366 Usual Rasidanca ot Decadant	ax 7. Aga (In yrs. ▼ M 2□F 58	last birthday) Yrs.	If Undar 1 Ya Months Da		n. (Month, Day,)		9. Birthplaca (Stata or Foraign Country) WASHINGTON, D.
10a. Stata 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Insida City Limits
MD PRINCE G	EORGES OXC	N HILI					1 Yas 2 No
10e. Straat and Number	Zorio Zo	, III	10f. Zip Cod	8.	100	. Citizan ot W	/hat Country?
4945 WEALDING WA	Ÿ		20745		7.13	מקודות כ	TRATEC AMEDICA
11. Maritai Status	12. Was Decedant Evar in U Armed Forcas?		Was Decedant	of Hispanic Origin?	Specify Yas or No-	14. Race	STATES AMERICA - Amarican Indian,
1 Navar Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas:		ir vas, specily C	uban, Maxican, Pua No <i>Specify:</i>	into Hican, atc.)		k, Whita, atc. BLACK
15. Decedent's Ed (Specify only highast gra	lucation da complated)	16e. Dece	dant's Usual Oc	cupation na during most of w	orkina 16	b. Kind of Bu	siness/Industry
Elementery/Secondary (0-12) 12th GRADE	Cotlege (1-4or 5+)	CLER	DO NOT usa rai	lired)		ED. GOV	7T.
17. Fathar's Nama (First, Middle, Last)				18. Mothar's N	ama (First, Middla, Ma	idan Sumami	a)
RALPH J. BRISCOE				ELSIE M	IAMLEY		
19a. Intormant's Name/Raiationship (7		Į.			Rural Routa Number, (Stata, Zip Coda)
SHIRLETA V. BRISCO					I.E., W.D.		
20a. Mathod of Disposition 1	Removal trom Stata	amatary, crar	natory or other	olace)	Data 20 26, 1998		City or Town, Stata
21. Signature of Funaral Seprice Licenter	1-21-	22			OHNSON & J		, INC.
23a. Parti. Enter the disaasa, or common shock, or haart tailura. List only to				1	ec or respiretory arres	le .	Approximate Interval Between Onset and Daath
Immediata Causa (Final disaasa or condition rasulting in death)	. Cardia	-c C	lares	8/-			30 minute
Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Diseasa or injury that initiated avants rasulting in death) Last	b. Myo C Dua to (o c. Hyper	ras e consequence of as a consequence of	para of):	Infan	rclian		> years.
Lasoning in death) Last	· Diale	fes	Mel	litus)		> 30 years
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27. Mannar ot Daath 1 To Natural 5 ☐ Panding 2 ☐ Accident Invastigation	28a. Data of injury (Month, Day Yaar)	28b. Tima of Injury		ijuryat Vork? □Yas 2□No	28d. Dascribe how	injury occurre	d
3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicida datarmined	28e. Placa of Injury - At he building, atc. (Spacify	oma, farm, stro	eet, factory, offic	00	28t. Location (Stree City or Town, S	et and Numbe Stata)	r or Rural Routa Number,
29a. Cartifier (Check only one) 1 Certifying Phy 2 Medical Exami	rsician: To the best of my know iner: On the basis of axaminet and mannar stated.	wledga, deeth ion and/or tny	occurrad at tha restigation, in m	tima, dete and plac y opinion, deeth occ	a, and dua to the causurrad at the time, date	sa(s) and mar and piace, a	nar as stated. nd dua to tha causa(s)
29b. Signature and title of certifier	0		29c. Lica	insa number	290	Data agnad	(Month, Day, Year)
Ala	y.		19	609	26	Jan	une 1998

The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that th within 24 hours after death.

To the Funeral Director: After this certificate has been signed by it completaly filled in by the funeral director, page 2 should be detact.

Physician

/Medical

Examiner

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other traumatic event, the Medical Experiment mat be notified at

Physician

/Medical **Examiner**

attending physicien and for use as the buriel-transit

the

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

Baltimore, Maryland 21215-0020

Director MD

Funeral

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Completed

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State Registrar 30 Nama and addrass deperson who completed cause of death (Item 23e) (Type, Print)

RAMAN R-TULI 3503 Perry Street MT. Railier MJ 20712

31. Data tiled (Month, Day, Year)

32. Registrar's Signatura

JUN 25 1998

July Street MT. Railier MJ 20712

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** Month JUNE 22, 1998 0320 AM SHERYL LYNN SNOWDEN BROCK /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 20 F Months Days Hours Min 39 Yrs. MARCH 28, 1959 WASHINGTON, D.C. **Director** 578-84-3387 Usual Residence of Decedent the Maryland 10e, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic svent, its Madical Examiner main be notified at 1 Yes 2 No Directo ALEXANDRIA **FAIRFAX** 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 22303 UNITED STATES AMERICA Funeral 2133 FARRINGTON AVE. death 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ② No
If Yes, Give
Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 X No Specify: Specify: BLACK 2 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2YRS, DISTRIBUTION PRIVATE 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) h end Mental STANLEY L. SNOWDEN DELORES E. SMITH 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 sh Department of Health end Important: If Itam 27 is m any injury or other traum once. STANLEY L. SNOWDEN (FATHER) 3628 18th ST. N.E., W.D.C. 20018 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremetion 3 Removal From State LINCOLN MEM. CEM JUNE 26, 1998 SUITLAND, MD. 22. Name and Address of Fecility JOHNSON & JENKINS, INC. 21. Signature of Juneral Service License 716 KENNEDY ST. N.W., W.D.C. plications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, one cause on each line. 23a. Part V Enter the disease, or com shork, or heart failure. List only Approximate Interval Between Onset and Death Physician Immediate Cause (Finel diseese or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Examiner certificata be executed physician and s the burial-trans Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 88 - esn Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably þ 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed completion of cause of deeth? has Yes 2 No 2 No Division of Vital or Attanding Physician: after death. Director: After this centific Be 25. Wes case referred to medical 28. Piece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: 1 Neturel 2 Accident Injury 5 Pending Subject divis h Bund 6/22/98 1 Yes Investigation 0422 Truck 28f. Location (Street and Number or Rural Route Number City or Town, Stele) | Length 2954 | | 81 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide shoulder Morderay 24 hours a Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JUNE 22, 1998 O.C.M.E 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 THEODORE 32. Registrar's Signature 31. Date filed (Month, Dey, Year)

Registrar

JUN 25 1998

DATE STATE HE IS NOT THE PROPERTY OF THE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** June 25, GUY MAURICE BADEN 1998 1:20 AM /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Adventist Health Care (BONC) Clinton Prince George's If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Deys 1 Ø M 2 ☐ F Yrs. 212-20-1642 85 Aug. 30, 1912 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Director Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 16601 Croom Road 20613 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 Never Married 2 Married 1 ☐ Yes 2 Ø No Specify: Specify: by 3 ☑ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) PG County Sheriff Police Officer 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Fether's Neme (First, Middle, Last) Be H. Albert Baden Lucy Murphy 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) James Baden-Nephew 15200 Croom Road, Brandywine, MD 20613 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1) Burial 2 Cremetion 3 Removel from Stete Trinity Memorial Gardens 6-27-98 Waldorf, MD 4 Donetion 5 Other (Specify) 22. Name end Address of Fecility
Huntt Funeral Home, Inc. M01095 David A. Goff P. O. Box 156, Waldorf, MD 20604-0156 Approximete Interval Between Onset end Death 23a. Pertif Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Immediate Ceuse (Finet disease or condition resulting in death) e. Dyrcardus Sarsingfreerag Examiner Sequentielly list conditions, if eny, teading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medicai Due to (or es e consequence of) Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a, Was en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 28e. Dete of tnjury (Month, Dey Year) 27. Menner of Deeth 28c. fnjury et Work? 28b. Time of 28d. Describe how injury occurred Naturet 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1) Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as stated.
2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end menner stated. Medical 29a. Certifier (Check only 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number Volomos & Freldon DOD 001923 JUNE 26, 1998 30. Name end eddress of person who completed cause of deeth (ttem 23e) (Type, Print) Thomas L. Fieldson, 2068 Crain Highway, Waldorf, MD 20601

Registrar

State

Funerai

Director

with the Maryland

Pages 1 and 2 should be filed within 72 hours eftar deeth with the Marylan nent of Health end Mantal Hygiene. shirt: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examines must be noutled as

Department of Important: If any injury or

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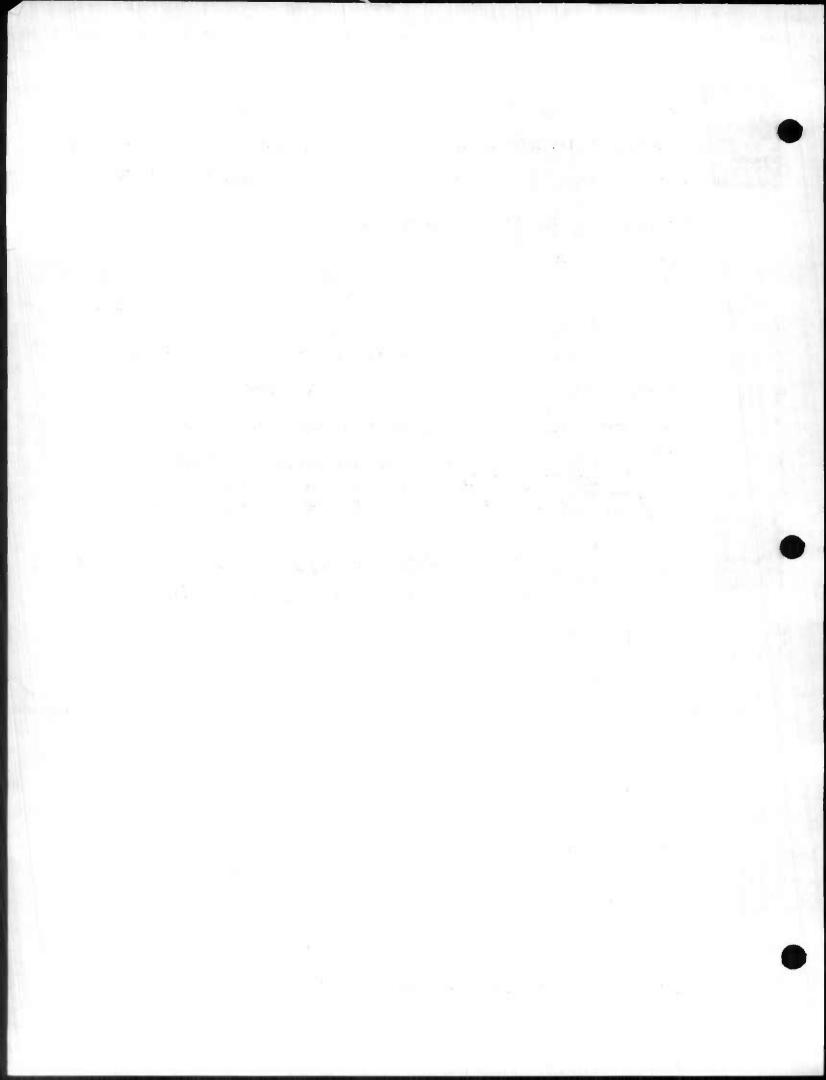
Examiner

or Attending Physician: The lew requires that the death certificete be axecuted

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0020

31. Date fited (Month, Day, Yeer)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** June 1998 9:44 p.m. Ellen Matilda Barrow /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Deys Hours 1 M 2 XF 218-05-1583 Yrs Director 83 June 29, 1914 Maryland Usuei Residence of Decadent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes XX No Directo Cecil Maryland Perryville 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 8 traumetic event, the Medical Examiner must be 23 224 Winch Road 21903 U.S.A. **Barna** 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bieck, White, etc. 11. Maritel Stetus 1 Never Merried 2 Married 6 1 Yes WNo Specify. Specify: þ ₩Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Six Years Homemaker Personal Residence 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 2 should be and Mental marked Walter Hickman Lulu Barrow 0 Pages 1 and 2 sh ment of Health and ant: If New 27 is m 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Janet M. Barrow (daughter) 224 Winch Road, Perryville, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete Important: If it any injury or o 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete West Nottingham Cemetery 7/1/98 Colora, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Fecility Lee A. Patterson & Son Funeral Home CITED TOOK OK. Perryville, Maryland 21903-0188 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner sician and burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest physician the burial Records, P.O. Box 68760 Physician/Medical 98 esn signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed hes certificate 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) 2000 Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 ☐ Yes 2 ER/Outpatient 3 DOA Inpatient After this funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturei 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined

Division of Vital

Certification: death. Director: or All To the Hospital or within 24 hours of To the Funeral D completely filled I Medical

State

3 Suicide

29a. Certifie

4 Homicide

(Check only one)

29b. Signeture and title of gr

JUN 3 0 1998

Registrar

30. Neme end add

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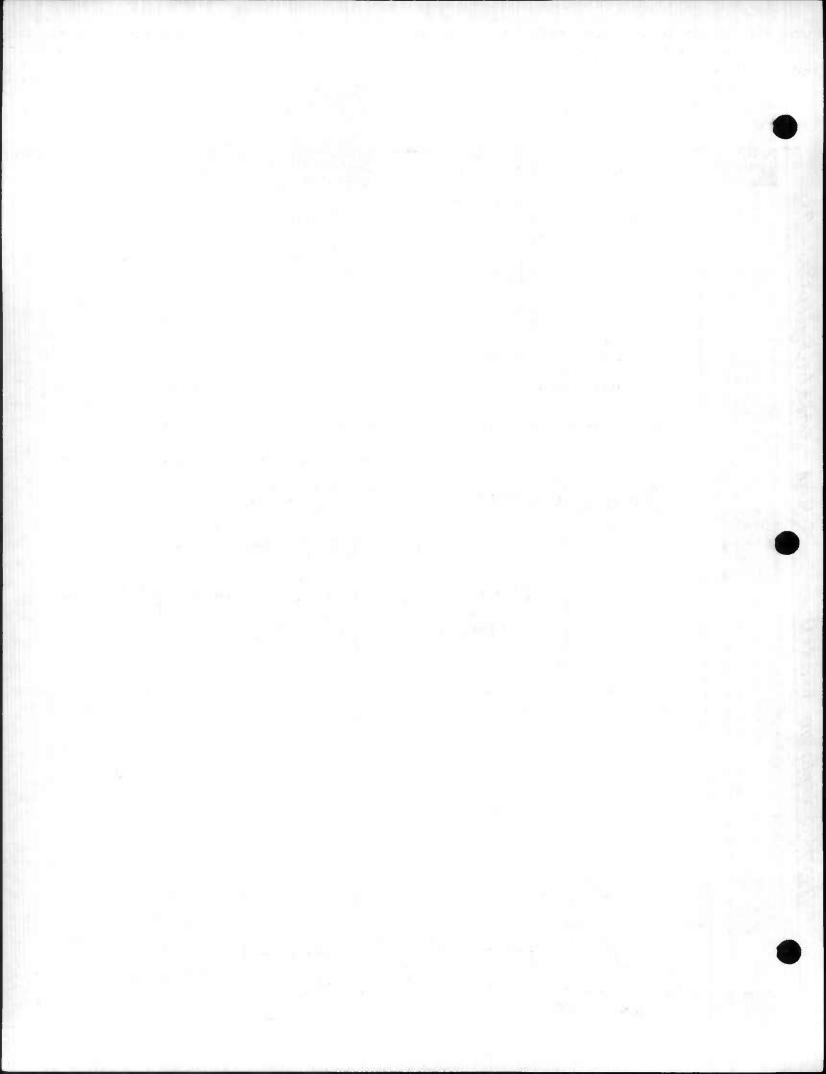
Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c: License number

Ecritifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

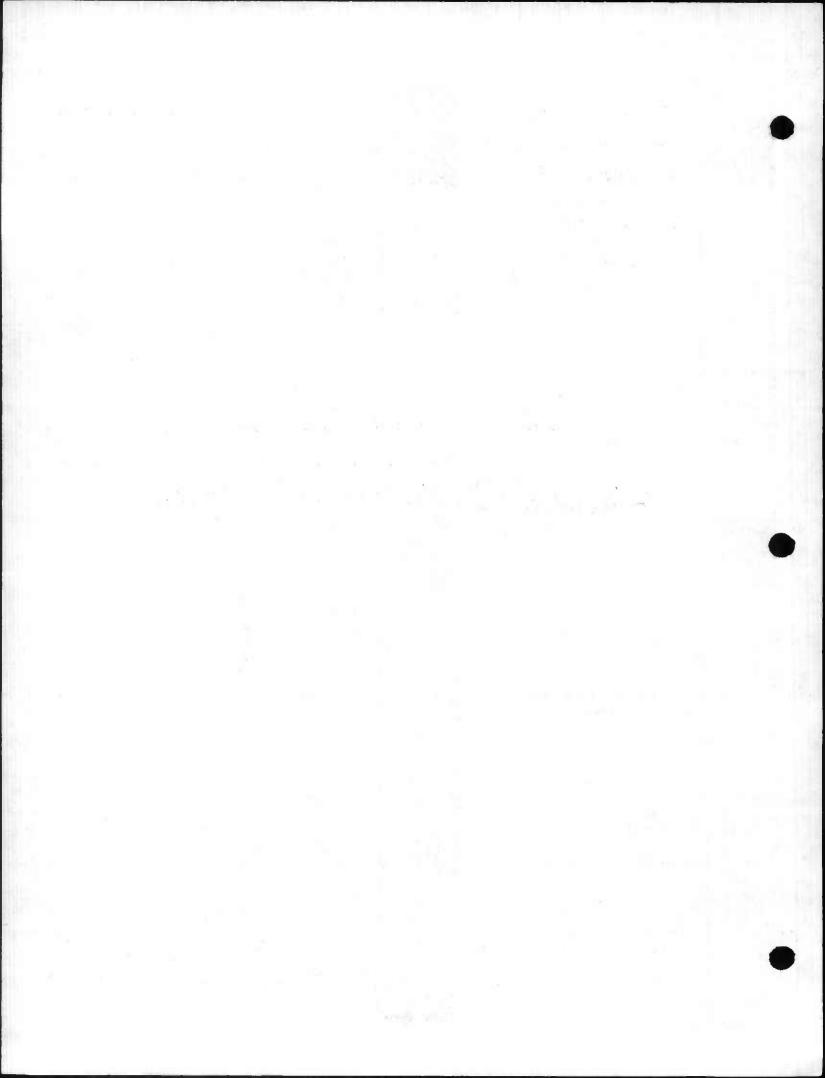
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28f. Location (Street end Number or Rural Route Number, City or Town, Stete)



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1	Formulat				7. Age (In yrs. last birtho	(ev) If Under 1 Yaar	If Undar 24 Hrs.	8. Dete of Birth			lece (State or Foreign
	Funeral Director		220-18-6193	10 M 2□ F	75 Yr	Months Devs	Hours Min.	8. Dete of Birth (Month, Dey, Dec. 16,	1922		lece (Stete or Foreign try) yland
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	h the Maryland r 28a-f show	Director	Maryland Ceci	.1	Elkton	10f. Zip Code		10	g. Citizan of V	What Coun	trv?
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21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiena. Itam 27 is marked other than "natural", or itams 23s or 28a-f show other traumatic avent, the Medical Examiner must be notified at	by Funeral	1 Never Merried 2 Merried 3 □ Widowed 4 □ Divorced	H Van Chu	ces?	if Yes, specify Cub 1 ☐ Yes 2 🔯 No	en, Mexican, Puerto	Rican, etc.)	Specify	k, White, o	
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Baltimore,	permit. Page Department of Important: If any Injury or office.		21. Signeture of Funeral Servica Lic	cansee	Prodie	22. Neme end Addre Robert T.	Jones &	Foard, I	nc.	,	
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State of Maryland / Department of Health and Mental Hygiene 9

					Ce	rtificate of	Death		Reg. No.		
	1. Decedent's Nama (Firs	t, Middle, La	ist)					2. Date of		Vana	3. Tima of Deeth
Physician	K	obert	Patterson	n Brane	d. Jr			June	,	Yeer 998	16:25
/Medical Examiner	4a Facility Name /Manak				u, 01		4b. City, Tow	n, or Location of D		y of Death	10.23
Cxammer			irsing Ce				E1	kton		Ceci	1
C	5. Social Security Number	6.5	Sex 7.	Age (In yrs. la	ast birthdey)	If Under 1 Yaar	If Under 2	Hrs. 8 Date of	f Birth		
Funeral Director	165-03-088 Usual Residence of Dece	5	1 M 2 □ F	88	Yrs.	Months Days	Hours	Min. (Month	29,1909	Penn	place (Stete or Foreigr ntry) sylvania
and and		County		10c. City,	Town or Lo	ocation				Τ.	10d. Inside City Limits
ith the Maryl or 28a-f she constituted	Maryland	Ce	eci1			Perr	yville				1 No Yes 2 No
th the	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Cou	ntry?
th wi		anding	g Court			2	1903		U.	S.A.	
72 hours after death with the Maryland "natural", or fisms 23a or 28a-f show solical Examiner must be notified at leted by Funeral Director	11. Marital Status	V) Married	12. Was Dacede Armed Forca	s?	6. 13.	Was Decedent of H if Yes, specify Cub	lispanic Origi an, Maxican,	n? (Specify Yas o Puerto Rican, etc.	r No- 14. Ra) Blo	ce - Ameri eck, White,	
ours at	3 □ Widowed 4 □ D		1 🕅 Yas 2 [If Yes, Give Yaar or Date:	s:WW II		1□ Yes 2☒ No	Specify:		Speci	1	White
	(Specify on		ada completed)		(Giva	dent's Usual Occup kind of work done DO NOT use retire	dunna most	of working	Peach Bot	Business/In Etom At	dustry Comic Power
filed within Hygiane. ther then and, the Ma	Elementary/Secondery	(0-12)	College (1-4c Two Year		Pt	ublic Rel	ations		Station,	Peach	Bottom, PA
Hyg Hyg		Middla, Last							ddle, Meiden Sume		
Se y w	5		Patterson	Brand	Sr			Lillie	Hamilton		
hould d Men marke	19e. Informant's Name/R			Dianu	-	ing Address /Street	end Number		umber, City or Tow	Stata Zi	n Code)
d 2 s th an 7 ls treu	Dorothea E.										yland 2190
a a a	20a. Method of Disposition		(WILE)	20b Ple		osition (Neme of	ding c	Date	20c. Location		
pemit. Pages 1 ar Department of Hea Important: If item; any Injury or other once.	1 Donation 5 0	mation 3		ta ca	metery, cre	metory or other ple ton Cemet					, Maryland
Department mporta	21. Signature of Funaral	Sarvica Lice	ubea /			2. Name and Addre					
SSESS	The	- 7	15.44		1	Lee A. Pa	tterso	n & Son	Funeral H	iome	
Physician	23a. Pert1. Enter the dis shock, or heart failu	ease, or com re. List only	pplications thet cause one cause on each	ed the death. I line.	. Do not en	itar tha mode of dyi	ng, such as c	ardiac or respireto	ory errest,		Approximete Intervel Between Onset and Death
/Medical	Immediate Cause (Final		P		1					-	1 1 1
Examiner	diseese or condition resulting in death)		θ.	neum	es e conse	overce of):					/ week 2 years.
i i			0	0. 0.		quence oi).				- 1	
executed in and rial-transit	One and the Manager Malay		b	agrees 10 for	es a conse	perman	12			1	2 years.
ata be hysicie tha bur	Sequentielly list condition if any, leeding to immedicause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest	ate	c		as a consec		H	+		1	
ath countitions for us		onditions (d	but not resul	Iting in the	underlying cause di	ven in Part I	23h.	Did tobacco use c	ontribute	to the cause of death
as that the de igned by the a be deteched by Physic			or mounting to down		and an area	,do,,g dd.dd g.			1□ Yes 2 No		obably 4 Unknow
na law requires that a has been signed b iga 2 should be date									Was en eutopsy performed?	a	Vere eutopsy findings vailable prior to
8 - 6 -									1□Yes 2ŒNo		ompletion of causa f deeth?
Physician: The this certificata ral director, par		modical	1				00 81				
sicien: certific lirector,	exeminer?	medical	Hospital:			Ot	hor -	of Death (Check of			26.4
Physician: this certific ral director, To Be			1 Inpe		ER/Outpatie 28b. Time o	INC 3LL DOA	4 MUN	-	Residence 8 00 ribe how Injury occi		ity)
Aftar fune fune		Pending Investigation	(Month, I	Dey Year)	Injury	Wo	rk?]Yes 2∐N		noo now injury coo.	31100	
A - 4	1 Naturel 5			Injury - At hor		treet, factory, offica	163 201	28f, Locati	ion (Street and Nun r Town, State)	nber or Rui	ral Route Number,
lor Attending after death. Director: After J in by the fune ertification	1 Maturel 5 D 2 Accident 3 Dicida 6 D 4 Homicide	Could not be determined	286. Place of	etc. (Specify,	,						
Hospital or Attent 24 hours aftar deat Funeral Director: stely filled in by tha dical Certifica	1 Maturel 5 C 2 Accident 3 Suicida 6 C 4 Homicide	Could not be determined	286. Place of	etc. (Specify, st of my know of examinati	vledge, deet			placa, and dua to			
Hospi 24 hour Funer stely fill	1 Maturel 5 2 Accident 3 Suicida 6 4 Homicide 29a. Certifier 1 (Check only one)	Could not be determined ertifying Pt ledical Example	building,	etc. (Specify, st of my know of examinati	vledge, deet		opinion, death	placa, and dua to		a, end due	to the cause(s)
he Hospi in 24 hou he Funer pletely fill edical	1 Maturel 5 2 Accident 3 Suicida 6 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title o	Could not be determined certifying Phedical Example cartifier	hysician: To the beminer: On the basis end manner	etc. (Specify, st of my know of examinati stated.	vledge, deet	29c. Licen	opinion, death	placa, and dua to a occurred et the t	ime, dete end place 29d. Date sign	e, end due	to the cause(s)
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Julia Davidson-Randall

DHMH 16 Rev 6/95

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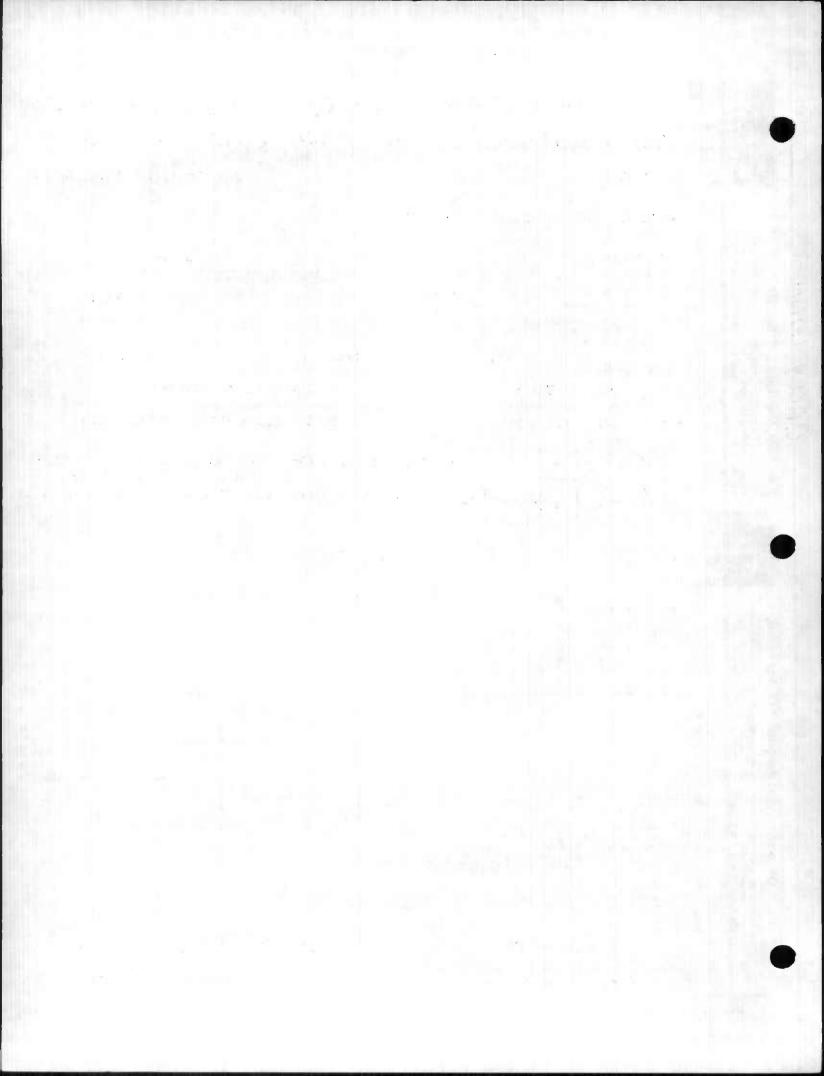
State of Maryland / Department of Health and Mental Hygiene

			Decedent's Name (First, Middle			-	rtificate of	Death		eg, No.	4	3. Time of Death
	Physic		Joseph Martin						Month	Day	Year 998	6:00PM
7.0	/Medi		4a. Facility Name (If not institution		(ber)			4b. City, Town, or I	June Location of Deeth	4c. County		0:00PM
	Exami	ner	Anne Arundel					Annapoli		Anne		del
-	Funeral		5. Sociei Security Number			. last birthday)	If Under 1 Year	r If Under 24 Hrs.				lace (State or Foreign try)
-	Director		N/A Usuel Residence of Decedent	6. Sex XXM 2□ F	3	38 Yrs.	Months Days	Hours Min.	Jan. 2,	1960	St.	Lucia
Manylend	f show	or	10a. State 10b. County	A d = 1		ity, Town or Lo					1	0d. Inside City Limits 1X Yes 2 □ No
the	28a	Director	Maryland Anne	Arundel	Ani	napolis	10f. Zip Code		1	0g. Citizen of V	What Cour	itry?
with	3a or	0	1130 Madison	St. Ant.	B3		21401					
5-0020 72 hours after death with the Marylend	of Mental hygiene. merked other then "natural", or items 23s or 28s-f show imetic event, the Medical Examiner invest be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Deced	dent Ever in U ces? 2X No			Hispanic Orlgin? (S ban, Mexicen, Puert Specify:	pecify Yes or No- o Ricen, etc.)	14. Rac Bled	e - America ek, White,	etc.
5-0 2 hou		ted	15. Deceden	t's Educetion		16a. Dece	dent's Usual Occu	petion		16b. Kind of Bu	usiness/Inc	dustry
vithin	Deperment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical ance."	Completed	(Specify only highest Elementery/Secondery (0-12)	st grade completed) College (1-	4or 5+)	_	kind of work done DO NOT use retire Man	ed) most of wor		Nautica	a 1	
	other other	Be C	17. Fether's Name (First, Middle,	Last)				18. Mother's Nar	ne (First, Middle, I	Ma <i>id</i> en Sumam	10)	
/lan	end Mental Hygi is marked other sumatic evant,	To B	Enude Auguste					Pauline	Clement			
Maryland	s me		19a. Informant's Name/Relations					t and Number or Ru	irel Route Number	, City or Town,		
2 2	Health Bm 27 i		Betty Clemen	t (wife)				St. Apt.	B3 Ann	apolis,	MD.	21401
S S	ent of H ht: If Itan ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 □Removal from S	late		esition (Name of matory or other place) e Cemete			20c. Location -		
Baltimo	Depentin Importar any injui		21. Signature of Funeral Service	-/-)		2. Name end Addr	oce of Encility				est Indies 1 Home Inc
			23a. Pert1. Enter the disease, or shock, or heart failure. List	XOU C	V			of Glouce	ster St.	Annapo		MD. 21401
	Medical and state of the private franction and state of the private franction and state of the private of the p	cal Examiner	Immediate Ceuse (Finel disease or condition resulting In death) Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	e	Due to (or as a consec	quence of):	hal m	rase			115
Box 68	ettending phy I for use as the	Physician/Medical	resulting in death) Last	d	Due to (c	or as a conseq	uence of):					
D. E	the ett	sic	Pert il. Other significant conditio	ns contributing to dea	ith but not res	sulting in the u	nderlying cause g	iven in Part I.	23b. Did to	bacco use co	ntribute to	the causa of death?
S, P.O	igned by the e be detached t	by Phy	Hyperte	20200	Esso	St	001	resal	1 🗆 Y	98 2⊠ No	3 ☐ Prol	pebly 4 Unknown
I Records, P.O. Box	s been s 2 should	Completed	disease						24e. Was a perform	n eutopsy ned?	ava	ere autopsy findings aliable prior to mpletion of cause deeth?
E 9	page 2	E O							1 □ Ye	s 2 No	10	Yes 2□ No
11 a	s certificate director, pag	Be	25. Was cese referred to medical					26. Place of Dea	th (Check only on	e)		
of Vital	0 0	10	examiner? 1 ☐ Yes 2 ENO	Hospitai:	patient 2	ER/Outpatien	t 3 DOA Ot	her: 4 Nursing H	ome 5 Reside	nce 6 DOth	er (Specif	1)
E 6	otn. :: After thi e funerel		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig		Injury Day Year)	28b. Time of Injury	Wo	ork?] Yes 2 ☐ No	28d. Describe ho	ow injury occurr	red	
DIVISION tal or Attending	within 24 hours aret deeth. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 286. Place C	of Injury - At h g, etc. (Speci	ome, farm, str	eet, factory, office		28f. Location (St City or Town		er or Rura	l Route Number,
Hospi	Within 24 hours arter To the Funeral Dire completely filled in t	edical	29e. Certifier 1 CertifyIng (Check only one) 2 Madical E	Physician: To the b Examinar: On the bas and manne	ils of examine	owiedge, death etion end/or inv	occurred et the ti restigetion, in my	ime, date end piece opinion, death occu	, end due to the ca rred at the time, do	ause(s) and ma ete and place, a	nner as st and due fo	ated. the cause(s)
Toth	Tott	M	29b. Signature and fitle of certifier				29c, Licen	se number	2	9d. Date signed	d (Month,	Day, Year)
			Gregero	1 Mit	tall	mp	D147	58	6	56.	98	
			30. Name and address of person of Gregory A. Mit					apolis, M	D. 21401			
	Sta Registr	- 1	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signe	eture	-d-00				184	

CAREY LONNIE

				epartment of He Certificate of D			ene 98	21082
hysician	Decedent's Name (First, Middle, LON)	Last) VIE THO	MAS	CAREY		2. Dete of Death Month		3. Time of Dec
/Medical Examiner uneral rector	4a Facility Nama (If not institution, s NORTH ARC	give street end number)	HOSPITH te (In yrs. last birthd	(ay) If Under 1 Yaar Months Devs	City, Town, or Local Company of Local Company			Deeth COUNTY Birthplece (State or For Country) LYNCHBURG,
Month and	Usual Residenca of Decedant 10a. State 10b. County		10c. City, Town o	r Location		1		10d. Inside City L
23a or 28a-f show ust be northed at ral Director	MARYLAND ANNE A	RUNDEL	GLEN BUI			100	g. Citizen of Who	1 Yes 2
23a or	10e. Street and Number 705 WIMMER ROAD			101. Zip Code 21061			S.A.	ot Country!
if, or items recover in by Funer	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forcas? 19 Yes 2 1 If Yes, Give Yaar or Detes:	Evar in U,S. No 1943-	3. Wes Decedent of His If Yes, specify Cuban	panic Origin? (Spec , Mexican, Puerto F Specify:		14. Raca - Bleck,	American Indian, White, etc.
other than "nature event, the Medical event, the Medical event, the Medical Be Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education greda completed) College (1-4or 5 N/A	16e. De (G iii	ecedent's Usuel Occupet live kind of work done du le. DO NOT use retired)	lon <i>tring</i> most of <i>workin</i>	ng	Sb. Kind of Busin	
event Be C					18. Mother's Neme			
metic event, I	OSCAR DEWITT 19e. Informent's Neme/Reletionship	CAREY (Type, Print)	19b. M	leiling Address (Street ar	JULIA ELL nd Number or Rural		GUSON City or Town, St.	ate, Zip Code)
er trau	REABEL CAREY-WI			WIMMER ROA		BURNIE, N		
or other to	20e. Method of Disposition 1 Burial 2 Cramation 3	□Removal from State	cematery,	isposition (Neme of cremetory or other pleca	1			ity or Town, Stete
Important: If Item 27 is marked other than any injury or other traumatic event, the Managas. To Be Comp	4 □ Donetion 5 □ Other (Spe 21. Signet a of Fune of Service Lie	• •		D VETERANS 22. Nama and Address	of Facility SIN	GLETON I	FUNERAL	
	23a Part1. Enter the disaese, or co	_)Face		1 SECOND AV				Approximete
dical niner Niner	Immediate Ceuse (Finel disease or condition resulting in deeth)	e	Due to (or es e cor	STATIC P			CEL	2 4 EM
as the burial-transit	Sequentielly list conditions, if eny, laading to immadiate cause. Enter Underlying Ceuse (Disease or injury thet initiated events rasulting in deeth) Last	c	Due to (or es e con	nsequence of):				
	thet initiated events	cd	Due to (or es e con	sequence of):		23b. Did tob	_	ibute to the cause of d
	rasulting in deeth) Last	cd	Due to (or es e con	sequence of):			eutopsy	
	rasulting in deeth) Last	c ds contributing to death b	Due to (or es e con	sequence of):		1 ☐ Ye	eutopsy ed?	24b. Were eutopsy find aveileble prior to completion of caus
	Pert II. Other significant conditions 25. Wes case referred to medical exeminer?	Hospital:	Due to (or es e con	isequence of): isequence of): isequence of): isequence of):	n in Pert I. 26. Plece of Deeth	1 Yes	eutopsy ed?	B Probably 4 Uni 24b. Were eutopsy find aveilable prior to completion of caus of death? 1 Yes 2 No
this connicate has been supportly the attending pay. "I director, page 2 should be datached for use as the conpleted by Physician/Medi	Pert II. Other significant conditions 25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth	Hospital: 1 ☐ Inpatie	Due to (or es e con ut not resulting In the ut not resulting In the ut not 2 d ER/Outputry 28b. Time	isequence of): iseque	n in Pert I. 26. Plece of Deeth	1 Yes	eutopsy ed?	B Probably 4 Uni 24b. Were autopsy find available prior to completion of caus of death? 1 Yes 2 No (Specify)
and director, page 2 should be datached for use as the state of the st	Pert II. Other significant conditions 25. Wes case referred to medical exeminer? 1 Yes 2 No	Hospital: 28e. Date of Inju (Month, De	Due to (or es e con ut not resulting In the ut not res	esequence of): sequence of): seque	26. Plece of Deeth 1. 26. Plece of Deeth 1. 4 \(\text{Nursing Homes} \) 26. Plece of Deeth 27. 2 \(\text{No.} \)	1 Yes 24e. Wes an perform 1 Yes (Check only one me 5 The Resider 28d. Dascribe how	eutopsy ed? s 29No nca 8 Other winjury occurred	B Probably 4 Uni 24b. Were autopsy find available prior to completion of caus of death? 1 Yes 2 No (Specify)
	Pert II. Other significant conditions 25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Netural 5 Pending investigat 3 Suicida 6 Could not determine 29a. Certifier 1 Certifying (Check only 2 Medical Ex	Hospital: 1 Inpatie 28e. Date of Inju (Month, De tion t be ed 28e. Pleca of injuiding, et	Due to (or es e con ut not resulting in th ut not resulting in th ent 2 ER/Output iny y Year) 28b. Tim inju ury - At home, farm c. (Specify) of my knowledge, d	estient 3 DOA Other of York M 1 Y	26. Plece of Deeth 26. No 20	24e. Wes an perform 1 Yes 1 Yes 1 (Check only one me 5 The Resider 28d. Dascribe how control of the control of the central due to the central of the cent	eutopsy ed? s 29 No nca 8 Other v injury occurred stete)	B Probably 4 Unit 24b. Were eutopsy find aveileble prior to completion of caus of death? 1 Yes 2 No (Specify) d or Rurel Route Number
and director, page 2 should be datached for use as the state of the st	Pert II. Other significant conditions 25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Netural 5 Pending investigat 3 Suicida 6 Could not determine 29a. Certifier (Check only one) 29b. Signeture end title of pertifier	Hospital: 1 Inpatie 28e. Date of Inju (Month, De tion t be ed 28e. Pleca of inj building, et	Due to (or es e con ut not resulting in th ut not resulting in th ent 2 ER/Output iny y Year) 28b. Tim inju ury - At home, farm c. (Specify) of my knowledge, d	sequence of): se	26. Plece of Deeth 26. Plece of Deeth 4 \(\text{Nursing Horizon} \) et 7 es 2 \(\text{No} \) 2 a, date end plece, e inion, death occurre	24e. Wes an perform 1 Yes (Check only one me 5 The Resider 28d. Dascribe how city or Town, and due to the cered et the time, date 29	eutopsy ed? s 22No nca 8 Other winjury occurred eet and Number Stete) use(s) end menn te and place, and d. Data signed (24b. Were eutopsy find aveileble prior to completion of caus of death? 1 Yes 2 No (Specify) d or Rurel Route Number and due to the cause(s)

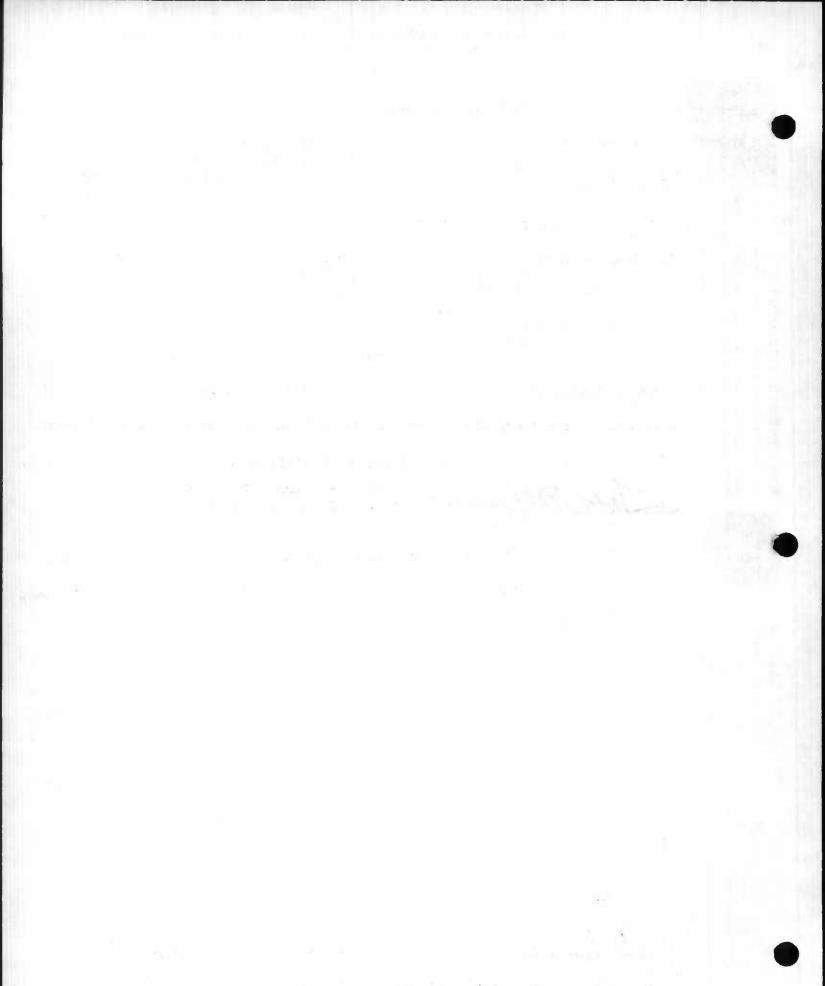
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

								ificate of	Death		Reg. No.	2	108	33
г	Physici	an	Decedent's Neme (First, M.	ddie, Last,						2. Dete of De Month	Dey	Yeer		e of Death
	/Media	cal	An English Name (Manainstite	atan aka	David T.	. Cava	anaugh		4b. City, Town, or L	June		998	10:	45am
)	Examir	ner	4e. Fecility Neme (If not institu		20 20 20 20 20 20 20 20 20 20 20 20 20 2									
			6630 Damascus 5. Sociel Security Number	Koac 6. Ser		e (In yrs. las	et hirthday)	If Under 1 Year	Laytons			tgome		to or Corrier
	Funeral Director		215-36-4360 Usuel Residence of Decedent	153	M 2□F	95	Yrs.	Months Deys		8. Date of Bir (Month, De Jan. 29	y, Year) 1,1903		owa	ite or Foreign
	Aarylend show	o.	10a. Stete 10b. Cou	nty			Town or Loc					1		e City Limits
	the A	Director	Maryland Mon 10e. Street end Number	togme	ery	Layt	consvi	10f. Zip Code			10g. Citizen of	What Cour	ta/2	
	With With			ъ.				2088	20				•	
	ns 23	era	6630 Damascus		l 12. Wes Decedent I	Ever in U.S.	13 W			necify Yes or No	United	e - Americ		1
Baltimore, Maryland 21215-0020	s 1 and 2 should be filed within 72 hours efter deeth with the Maryland I Health and Mentel Hygiene. If the marked other than "natural", or items 23a or 28a-f show other traumatic event, its Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 ☑ N 3 □ Widowed 4 □ Divor	farried	Armed Forces? 1 ⊠Yes 2 □ N If Yes, Give Yeer or Detes:	No	1	Yes, specify Cub ☐ Yes 2 ☑ No	Hispenic Origin? (Spean, Mexican, Puerto Specify:	Rican, etc.)	Specif.	ck, White,	etc.	
Ö	2 hou		15. Dece	dent's Edu	cation		16e. Decede	ent's Usuel Occu	petion		16b. Kind of B			
215	nin 72	Completed	(Specify only hig Elementary/Secondary (0-1	hest gred	e com <i>pleted)</i> College (1-4or 5	. \	(Give k	ind of work done O NOT use retire	during most of world)	king				
21	d with	Eo	Elementary/Secondary (0-1	2)	6	+)	Atto	orney			Gover	nment		
pu	be filed withing the Hygiene. d other than svent, the M	Bec	17. Fether's Neme (First, Midd	lie, Last)					18. Mother's Nem	ne (First, Middle,	Maiden Sumen	ne)		
<u>la</u>	should be fand Mentel I smarked or	ToE	Thomas A. Cav	anaug	gh				Louise	Lawler				
lan	2 sho i end h is me		19e. Informent's Neme/Relati				19b. Meiling	Address (Stree	t end Number or Ru	ral Route Numb	er, City or Town,	State, Zip	Code)	
Σ.	Health Health em 27 i		Elizabeth C.	Cavar	naugh/Wife		6630	Damascus	Road, La	aytonsvi	ille, Ma	rylan	nd 20	0882
ore	of He		20a. Method of Disposition 1 St Burial 2 ☐ Cremetic	. a □□	tomoval from State	20b. Plea	ce of Dispos netery, crem-	ition (Name of etory or other ple	ice)	Dete	20c. Location	- City or To	wn, Stete	9
Ĕ	Peges nent of I ant: If its		4 □ Donetion 5 □ Other		temover from Stete	Gat	e of H	eaven C	emetery 6	/23/98	Silve	r Spr	ing,	Marylan
alt	permit. Peges 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signeture of Funeral Serv	ce License	90		22.	Name end Addre	ess of Fecility			17		
m	20 = 20		bodel	1	Ukny	w			lesworth ge Road, l				208	7.2
	Physiclan		23a. Pert1. Enter the diseese shock, or heart fellure. I	or compli ist only or	icetions thet caused ne ceuse on each lin	the death.	Do not ente	the mode of dy	ing, such es cardiac	or respiretory e	rrest,	anu	Approxi	
7	/Medical Examiner		Immediete Ceuse (Final diseese or condition resulting in death)	6	Aspi	RATI	102)	ruem	onia scular c				14	years
		ē			m. 1	Due to (or e	e consequ	ence of):	10.10	a.c. A	10.10		5.	
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ion o	Attanding Physician: or death. octor: After this certific by the funeral director,		27. Manner of Deeth 1 Deture 5 Per 2 Accident	ding estigation	28e. Date of Injur (Month, Day	y Year) 2	8b. Time of Injury	28c. Inju Wo M 1	nyat nrk?]Yes 2□No	28d. Describe	how Injury occur	rred		
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			State of W	-	Certificate of			3. No. 9 8 2	1084
Physic /Med		Decedent's Name (First, Middle, Last Evelyn	Americ	a C	RAMER		2. Dete of Deeth Month June 19	, 1998 Yeer	3. Time of Deeth 1:10 PM
Exam		4e. Facility Neme (If not institution, give Frederick Health		ter		4b. City, Town, or Lo Freder:		4c. County of Deat Frederi	
Funera Directo		217-10-0100	ex 7. Ag	e (In yrs. last birth 79 Y	nday) If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, Aug 20,	1918 9. Birt	hplece (State or Foreign unity) aryland
Maryland F-1 show	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Freder.	ick	10c. City, Town Frede	or Location Prick				10d. Inside City Limits 1 Yes 2 No
ith with the 23e or 28e	Funeral Director	10a. Street end Number 30 North Place		1	10f. Zip Code 21	701	109	g. Citizen of Whet Co U.S.	
d 21215-0020 filed within 72 hours after death with the Maryland Hygiena. ther than "naturel", or Hems 23a or 28-4 show ent, the Medical Exercises		11. Meritel Stetus 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorcad	12. Wes Decedent Armed Forces? 1 ☐ Yes 2 2 4 If Yes, Give Yeer or Detes:		13. Wes Decedent of H If Yes, specify Cub- 1 ☐ Yes 2X No		ecity Yes or No- Rican, etc.)	14. Raca - Ame Bleck, White Specify: W	
ire, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours aff f Health and Mental Hyglena. Item 27 is marked other than "naturel", or other traumatic event, II a Marical Experi	Completed by	15. Decedent's Ed (Specify only highest gra- Elementery/Secondery (0-12)	ucation de completed) College (1-4or s	(Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire med/Operato	during most of work d)	ing	Restuaran	
faryland 2 2 should be filed and Mental Hygi is marked other surmatic event, I	Be	17. Fether's Neme (First, Middle, Last)				18. Mother's Neme			
Maryland d 2 should be file th and Mental Hy 7 is merked oth traumetic event	T _o	C Oscar 19e. Informent's Neme/Reletionship (7)	Type Print)	DeGrang	Se Meiling Address (Street	Carrie	Rebe		SMITH In Code
Baltimore, Ma bernit. Pagas 1 and 2 s Departmant of Health ar mportant: If item 27 is inty injury or other trau		Paul E. DeGrange	Brother Removel from State	20b. Plece of licemetery	3518 Dogwood Disposition (Name of crematory or other pla Livet Cemete:	d Road, F	t Myers I		Town, Stete
Baltimor permit. Pagas 1 Department of F important: If the any injury or of		4 Donetion 5 Other (Specify 21. Signeture of Funeral Service Licen	<u>.</u>	-M00706	22. Name end Addre Keeney at	ess of Fecility and Basford	d P.A. Fu	neral Homerick, MD	ne
BOX 08 / 00, leath certificate be executed white the second attending physician and attending physician and second for use as the burial-transit	edical Examiner	23e. Fart. Enter the disease, or compshock, or heart feilute. List only of the second	eb		onsequence of):				Approximete Intervel Between Onset end Deeth
d by tha	eted by Physician/M	Per II. Other significant conditions of	entributing to death b		the underlying cause given PV	ven In Pert I.	23b. Did tob 151 Year 24e. Wes en perform	autopsy 24b.	to the cause of death' robably 4 Unknow Were eutopsy findings aveilable prior to completion of cause
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DIVISION To the Hospital or Attending P within 24 hours aftar death. To the Funeral Director: Aftar t complately filled in by the funeral	edical Certi	29e. Certifier 17 Certifying Ph	building, et	c. (Specify) of my knowledge,	death occurred et the ti			use(s) end manner as	
To the P within 2- To the F complate	Medi	29b. Signeture end title of certifier	end menner st	My	29c. Licens		29	d. Date eigned (Mont June 19,	h, Day, Year)
		30. Neme end eddress of person who design the state of th	an 30	tp w c	Cype, Print)	Luder	umd	21761	
S [.] Regis	tate trar	JUN 9 \$ 100	a January Park	er's Signeture					

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month 24, 1998 6:10 P.M. **Physician** Corbet Lo₁a Ruth /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) March 28, 1905 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sax **Funeral** Months Days Hours Maryland 1 M 2 TXF 93 Director 220-18-0019 Usual Rasidance of Decedant with the Marylend 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be not the dia Maryland Frederick Frederick 1€ Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 12 West 14th Street 21701 U.S.A. Funerai deeth 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status Black, Whita, atc. permit. Pages 1 end 2 should be filed within 72 hours eftar c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item any Injury or other traumetic event. It is lead to the 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Spacify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 11 Cafateria worker Public School System 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Surname) Be Jesse Belle Effie Fannie Harris 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Nama/Ralationship (Type, Print) Mary E. Lambert/Daughter 9328 White Rock Ave., Frederick, MD 21702 20b. Place of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State 4 Donation 5 XXXXIII Combment Mount Olivet Cemetery June 26, 1998 Frederick, MD 22. Name and Addrass of Facility un of Funeral Service Lie 1000021 Keeney & Basford Funeral Home 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in daath) /Medical Examiner Examiner 10Wa ician and burial-transit Sequentially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disaasa or Injury that Initiated avants resulting in death) Last Dua to (or as a consagnance of): certificate be execu physician a Box 68760 Physician/Medical Dua to (or as a consequence of): 980 23b. Did tobacco uss contributs to the causa of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. signed by t 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records, Ď, 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy performed? Deen completion of ceuse of death? has 1 Yas 2E No 1 ☐ Yas 2 ☐ No funaral director, Be 25. Was cesa rafarrad to medicel axaminar? 26. Placa of Death (Chack only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No + Inpatiant 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: After Natural 5 Panding invastigation Injury 1 ☐ Yas 2 ☐ No death. 2 Accidant or Attand after death Director: / 6 Could not be datarmined 3 Suicida Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Hospital
 24 hours a
 Funeral C 1 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Cartifiar Medicai (Check only one) To the Within 2 29b. Signatura and illia 29d. Date signed (Month, Day, Year) 29c. License number 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) Edward P. Riuli, M.D., 310 West Ninth Street, Frederick, Maryland 21701 Ragiorar's Signature 31. Data filed (Month, Day, Yaar) State

DHMH 16 Rsv 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month 5:58 PM Barbara Ann Caldwell JUNE /Medicai 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctors Hospital Lanham If Undar 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foraign **Funerai** Days Hours 1 ☐ M 2 🔀 F **Yrs** 579-58-0775 53 1944 Washington, D.C Aug. 18, Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits a 28a-f show a notified at 1 X Yes 2 □ No Director Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 20746 1124 Campbell Dr. United States by Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) Race - American Indian, Black, White, atc. AREARA AND CALLLO 1 ☐ Never Married 2 ☐ Married 1 TYas 2 No Specify: Black 1 Yas 2 No Specify: 3 Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retirad) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Program Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Haskell P. Caldwell Mary Holton 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5015 Fitch Pl. N.E. #23 Washington, D.C. 20019 Rhonda M. Caldwell/ Daughter Bern 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 7/1/98 Washington, D.C. 4 ☐ Donation 5 ☐ Othar (Specify) Mt. Olivet Cemetery 22. Name and Address of Facility
Alexander S. Pope Funeral Homes 21. Signatura of Funeral Service Licensee 5538 Marlboro Pike/ Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Approximate Interval Batween Onset and Daath **Physician** Immediata Cause (Final disaase or condition resulting in death) /Medical a. CARDIDGENIC EVENT (ARRYTHMIA VS INFARET)
Due to (or as a consequence of): SWOOEN **Examiner** Examiner DENO STAGE CHROMIC RENAL FHILLIKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) HyperTENSTON · ACCELERATED thet initieted events rasulting in death) Last Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? Completed completion of causa of death? or Attanding Physician: 25. Was case refarred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide Hospital edicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. completaly 2 Medicat Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29b. Signature and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) 8118 GOOD WICK ROAD ess of person who completed cause of death (Item 23a) (Type, Print) DOCTORS COMMUNITY HOSPITAL SOCOC OM MAHMAN 32. Registrar's Signeture State

DHMH 16 Rav 6/95

Registrar

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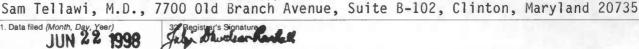
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AND THE TOTAL OF SECURITY SERVICES AND AND ADDRESS.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Month 17 **Physician** CLIFTON E. COSEY. JR. 4:30 PM June 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not Institution, give street and numbar) Examiner 124 Swiss Gap Prince George's Upper Marlboro Year If Under 24 Hrs. 8. Date of Birth
Davis Hours Min. (Month, Day, Yeer) If Under 1 Birthpleca (State or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. lest birthdey) **Funeral** 1X M 2 ☐ F 578-42-7323 65 Yrs September 1, 1932 Washington, D.C. Director Usual Residence of Decedent filed within 72 hours after death with the Marylend 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yas 2 □ No Maryland Prince George's Upper Marlboro Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 124 Swiss Gap 20774 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 Ø Yes 2 □ No 11/23/49 If Yes, Give 11/24/51 14. Race - Amarican Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Naver Married 200 Married 1 ☐ Yas 2 X No Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16h Kind of Rusiness/Industry College (1-4or 5+) Elementary/Secondery (0-12) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygiens important: If Item 27 is marked other that any injury or other traumatic event, Italian 2006. Ink Maker Government 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Clifton E. Cosey, Lucille Lucas 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jacqueline Cosey/Wife 124 Swiss Gap, Upper Marlboro, Maryland 20774 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete 06/23 1 Buriel 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 1998 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansed J. B. JENKINS FUNERAL HOME Nanc Perca 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in death) 2 years Examiner Physician/Medical Examiner The law requires that the deeth certificate be executed ettending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or as e consequence of) Box 68760, thet initieted events resulting in deeth) Last Due to (or as e consequenca of) signed by the e 23b. Did tobacco use contributa to the ceuse of death? Division of Vital Records, P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to Completed completion of cause of death? certificate has 1□ Yes 2 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to mediea exeminer? Be 26. Place of Deeth (Check only one) rs after death. Hospital: 1 | Inpatiant 2 | ER/Outpetlent 3 | DOA Other: 4 Nursing Home 5 Desidence 8 Other (Specify) 1 Yes 2 No 2 28d. Describe how injury occurred 28b. Time of 27. Mannar of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 5 Pending investigation or Attending 1 ONature 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Destriying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai completely 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end pieca, and due to the cause(s) and mannar stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

6 Registrar

31. Data filed (Month, Day, Yeer)
JUN 22 1998



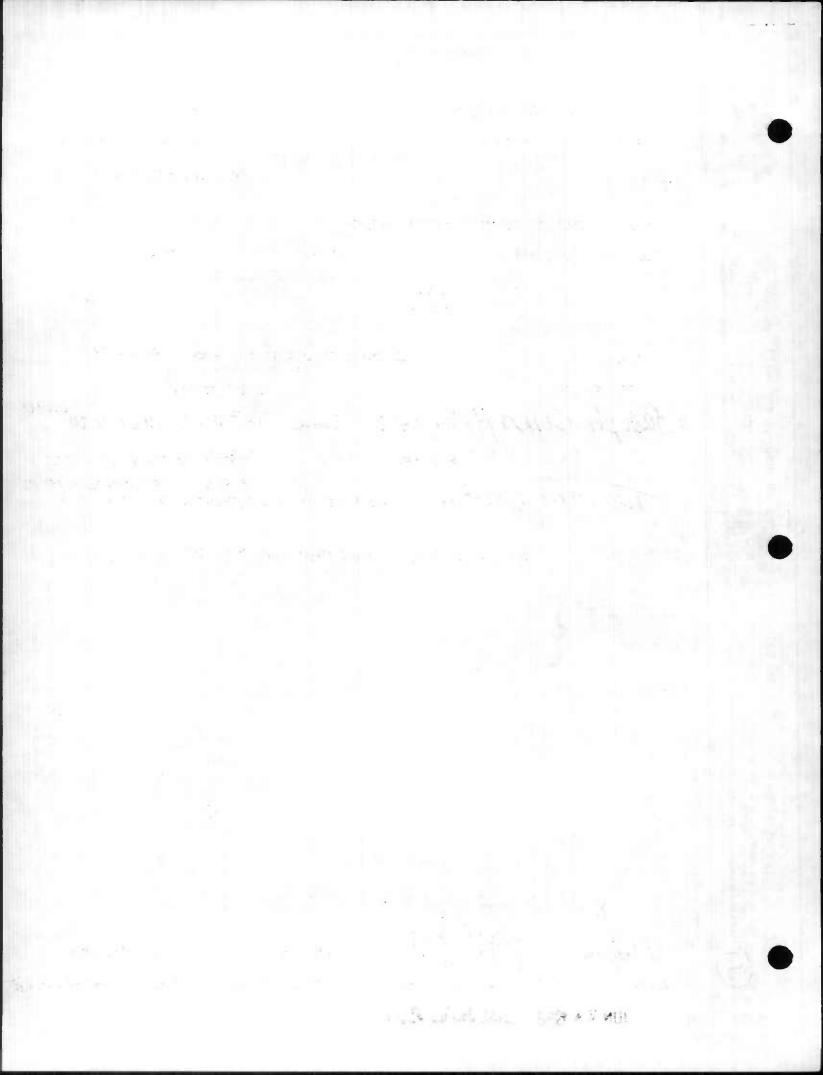
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 2 1000

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			1. Decedent's Neme (First, Middle, La	st)			DOM:	2. Dete of De Month	eth Day	Year	3. Time of Death
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	Funeral Director		5. Social Security Number 6. S 411–59–6606 Usuel Residenca of Decedent	Sex 7. A	ge (In yrs. lest bin	thday) If Under 1 Y Yrs. Months D	eys Hours Min.			9. Birthpl Count MEMPH	lece (State or Foreign try) HIS, TENN.
	land Mand		10a. State 10b. County		10c. City, Town	or Location				10	0d. Inside City Limits
	Mar and	cto	MARYLAND PRINCE	GEORGE'S	UPPER	MARLBORO					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Co			10g. Citizen of V	What Coun	try?
	23.		4706 HALLORAN C				0772		USA		
21215-0020	urs a	by Funeral	11. Marital Status 1XXVever Married 2 Married 3 Widowed 4 Divorced	12. Was Dacedani Armed Forces 1X Yes 2 If Yes, Give Yaar or Datas:	1 Evar in U,S. ? 1No NAVY 1994–1998	13. Wes Decedant If Yes, specify 1 ☐ Yes 2	of Hispanic Origin? (S Cuban, Maxican, Puar No Specify:	Specify Yas or No to Rican, etc.)	Specify	a - America ck, Whita, e	
5-0	natur olesi	Completed	15. Decedent's E	ducation		Decedent's Usuel O (Giva kind of work d	ccupation one during most of wo stired)	orking	16b. Kind of Bu	usiness/Ind	Justry
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Maryland	s marked o	0	19e. Informent's Nemer Reletionship (7 . 1 196	. Meiling Address (S	treet and Number or R			Stete, Zip	Code) 20120
	and 2 selth ar n 27 is		18AODH CE	hen H	ather 1	40109 L	otus Lar	x#927	Centre	ville	Va
re,	of Heelth of Heelth f Itam 27 r other tr		20a. Method of Disposition			Disposition (Neme or other	of placa)	Dete	20c. Location -	City or To	wn, Stete
altimore,	Pages nent of I mt: If Its my or o		1 ☐ Burlel 2 ☐ Cremetion 3 ▼ 4 ☐ Donetion 5 ☐ Other (Special	IRemovel from State y)	9	AL CEMETE		6-29-98	MEMPHIS	, TEN	NESSEE
alt	permit. Pag Department Important: fi any Injury o		21. Signeture of Funerel Service Licer	1800 /	1	22. Neme end A	ddress of Facility	MARSHATI	L'S FIME	DAT. I	HOME OF MD
m	Ped die die die die die die die die die d		Tuawang	Brax	ton	4308 SUT	TLAND RD.				20746
-			23a. Pert1. Enter the diseese, or com shock, or heart feilure. List only	plications that cause one ceuse on each	ed the deeth. Do r						Approximete Interval Between
1	Physician										Onset and Death
4	/Medical Examiner		Immediate Ceuse (Finel disaese or condition resulting in death)	. HYPERT	ENSIVE	CARDIO	VASCULAR	PISEASE	= & 1	MPH	omA
		- E	,		Due to (or es e	consequenca of):					
	d ansit	Examiner		b	Due to for or a	consequence of):				i	
Ć.	be axecuted sician end burial-transit		Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury		Due to (or es a t	consequence or).					
68760,	ifficate be avacuted g physician end as the burial-transit	edical	Ceuse (Disease or injury that initiated events resulting In deeth) Lest	C	Due to (or es e o	consequenca of):					
			resulting in deeth) Lest	. 44							
Box	attendin for use	2		d		76.0				1	
	the a	Physician	Pert II. Other significant conditions of	ontributing to death	but not resulting Ir	tha underlying caus	e given in Pert I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
P.0	ed by the dateched							10	Yes 2□ No	3 Prot	bably 4 Unknown
Records,	8 5 3	a D						24a Was	an autopsy	24b. Wa	ara autopsy lindings
202	been signatured should to	ere						perfe	ormed?	CON	eileble prior to mpletion of cause deeth?
Re	The law ete has page 2	Completed							Yes 2 No		Yes 2□ No
Vital			25. Wes case referred to medical				26 Place of De	eth (Check only			1198 20140
<u> </u>	Physician: this certificated director,	0 00	examiner? 1 Nes 2 No	Hospitel:	ient 2 ER/Ou	tpetient 3 DOA	Other: 4 Nursing	10	Idence 6 🗆 Oth	er (Specifi	v)
υot	E E = .		27. Manner of Deeth 1 ANetural 5 ☐ Pending	28e. Dete of Inj (Month, D	ury 28b. 1		Injury et Work?	-	how injury occur		
Division	Attending or death.	Certification:	2 ☐ Accident investigatio	n		M	1 ☐ Yes 2 ☐ No				3 10 10
N N	or Attendi after death. Director: A 1 in by the fu	Ě	3 Suicide 6 Could not be determined	289. Piece of in	njury - At home, fa tc. (Specify)	rm, street, lectory, of	fica		Street end Numb wn, State)	er or Rura	I Route Number,
	oltal ours a curs a cur		00-0-45-								
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completaly filled in by the	Medical			of examinetion en		ne time, data end plac my opinion, deeth occ				
	ompk	Z	29b. Signature and titla of cartifier	Tat 1	0	29c. Li	cansa number		29d. Dala signe	d (Month, i	Day, Year)
	0-15-0		D/WIMM	U/HARV	MANI	0.	2200		MAILE	21 1	090
	(3)		30. Neme and eddress of person who	completed cause of	death otem 23e)	(Type, Print)	77/14		JUNE	41	-118
	0		MARIO # GOL	LEY . TR	NO 3	001 HOS	PITAL DR	IVE CH	EVERLY	MA	RYLLUD 207
	State	e	31. Dete filed (Month, Dey, Year)		trar's Signeture				,	1	
	Registrar	r	JUN 2 4 199	8 Jalli d	Studen Re	well					

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

_			1 December 1/2 Name (Cont. Alfallia, Local	Otate of Mid	il ylaira		tificate				Reg. No.	} 2	1089
п	Physici	an	Decedent's Name (First, Middle, Lest)							2. Data of De Month	Day	Year	3. Time of Death
J.	/Medic		Eleanore Barbara (4a. Facility Nama (If not institution, give s		er				4b. City, Town, or	June	18,199	8	21615
ji.	Examir	ier	919 Kirk Road	street end number)				1		Location of Deal	h 4c. County	of Death	Cocil
ı	Funcusi		5. Social Security Number 6. Sax	7 Ana	(In yrs. las	t hirthday)	if Undar 1	Yaar	Elkton If Under 24 Hrs.	8. Data of Bi	th	D Right	Cecil
L	Funerai Director			M 280 F	57	Yrs.		Days	Hours Min.	(Month, Di	6, 1940	Dela	placa (Stete or Foreign ntry) IWare
	Aaryland ed m	or	10a. State 10b. County			Town or Loc	cation					1	10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	28a-i	Director	Maryland Cecil 10e. Street and Number		Elkt	ton	10f. Zip C	20do			10a Citizan of 1	Afbat Cau	
	with the or	5	919 Kirk Road					2192	. 1		10g. Citizen of 1		
	death	Funeral		12. Was Decedant E	ver in U,S.	13. V				pecify Yes or No			can Indian,
020	72 hours after death with the Maryland "natural", or frems 23a or 28a-f ehow polical Examiner mant be notified at	by	1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	0		Yes, specif		ispanic Origin? (S en, Maxican, Puert Specify:	o Rican, etc.)	Specify	ck, White,	
21215-0020	C ' 4	Completed	15. Decedent's Educ (Specify only highest grade	completed)		16e. Deced (Give I	ent's Usual kind of work	Occup done	ation during most of wor	king	16b. Kind of B	usiness/in	dustry
	d wit	Comp	Elementary/Secondery (0-12)	College (1-4or 5-	+)		emaker		,	-			
and	od ala	Be	17. Father's Name (First, Middle, Last)						18. Mother's Nan			10)	
Z	d 2 should be the end Mental of 1s marked or treumatic ever	L O	Leon Kowalski								n Bigos		
, Maryland	nd 2 sith er 27 ls r treu		19a. Intorment's Name/Relationship (Ty) James Christopher		and				end Number or Ru l, Elkton) Code)
Baltimore,			20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ R: 4 ☐ Donetion 5 ☐ Other (Specify)	emoval from State	Imma C	culate	sition (Neme netony or oth Conc	e of cept cept	ion J	une 23, 1998	20c. Location - Cherry Marylan	Hill	
Balt	permit. Pege Department of Important: If I any injury or 90009.		21. Signature of Funerel Service License	o Histo	Ca				s of Fecility For Fun Stockton		P.A.		and 21921
			23a. Part1. Entar the disease, or complications, or heart failure. List only on	cations thet causad to cause on each line	tha death.	Do not enta	r tha mode	of dyln	g, such as cardiac	or respiretory e	rrest,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a	Lung	Ca	ncer						1	2 years
		Jer	rosuling in death)			s e consequ							
	rificete be executed g physician and as the buriel-transit	Examiner	Sequentially list conditions, if any leading to immediate		ue to (or e	s a consequ	uence of):						
68760,	sician sician e bune	edical E	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events		ue to (or ea	s a consaqu	ience of):						
x 68	2 00		resulting In deeth) Last		de to (or as	a consaqu	rance ory.						
Box	death cert e ettendin ed for use	Physician/M											
P.O.	the d	yslo	Part II. Other algnificent conditions con		not resulting	ng In the un	derlying cau	use giv	en In Part I.	23b. DId	tobacco use co		o the cause of death?
	es that the igned by be detect	by Pr	Multiple Scher	rosis						100	Yes 2□No	3 Pro	bably 4 Unknown
Records,	v requir been s should	Completed									en eutopsy ormad?	av	vere eutopsy findings vailabla prior to completion of cause death?
	The ate h	Com								10	Yea 2 No		☐ Yes 2☐ No
VIE S	clan	Be	25. Was case referred to medical examinar?	oppital:				Out	26. Place of Dec	th (Check only	one)		
of Vital	this aldi	5 To	1 ☐ Yes 2 No ☐	ospital:		VOutpatiant		-	4 Li Nursing n		dence 6 □Oth	-	y)
Ion	ath. r: After e fune	atlon	Natural 5 Pending Accident Investigation	28a. Date of Injury (Month, Dey	Year)	Bb. Time of Injury	M	c. Injun Worl	yat k? Yes 2 □ No	280. Describe	how injury occur	red	
Division	To the Hospital or Attanding Physician: within 24 hours after death is set of the Funeral Director. After this certific completely filled in by the funeral director.	Certification:	3 Sulcide 6 Could not be determined	28e. Place of Injur building, etc.		e, farm, stre	et, factory,	office		28f. Location (City or To		er or Rure	al Route Number,
	hours a neral C y filled		29a. Certifier Contifying Physics (Check not)	Ician: To the best of	my knowle	dge, deeth	occurred et	the tin	ne, dete end plece	, end due to the	ceuse(s) end ma	anner as s	dated.
	the Ho hin 24 the Fu The Fe	Medical	one)	er: On the basis of and manner stet	xeminetion	end/or inve	estigetion, ir	n my o	olnion, death occu	rred et the time,	dete and piece,	end due to	o the ceuse(s)
	To Vill	-	29b. Signatura and title of certifier	1.	10				a number		29d. Date signe		
	10-		30. Name end address of person who cor	May, p	VD	Pol (Time F	2 T	1	7)/4		June	7,/	998
	V		HI Farkes, r	NO UN.	A /	Uvr 1	ern C	che	5314 spake	Hospice	Elkton	n, r	20
	Sta Registr		JUN 2 5 1998	32. Registrar	's Signatur	mobile			•	1			

State of Maryland / Department of Health and Mental Hygiene

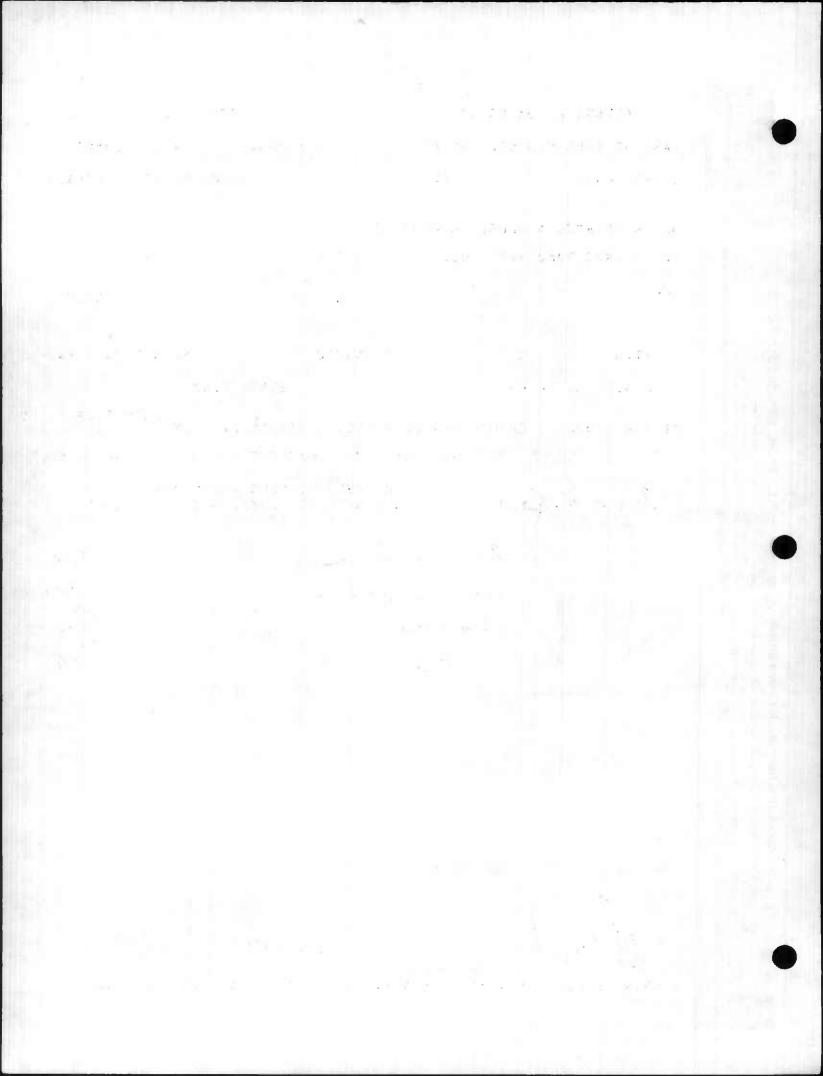
Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Arlene L. Calhoun June 23, 1998 1800 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Laurelwood Continuing Care Center Elkton Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Min. (Month, Day, 1847) February 5, 1□M 20 F Months Yrs. 1916 Pennsylvania Director 191-24-9707 Usual Residence of Deceden death with the Marylend 7 is marked other than "natural", or itema 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 100 Laurel Drive 21921 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Btack, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter to Department of Heelih and Mentel Hygione. Important: If item 27 is marked other than "natural", or item any finlury or other traumatic event, I'm Medical Examina 1 ☐ Naver Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 White 1 Yes 2K No Specify: Specify: 2 3 ₩idowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker 17. Father's Name (First, Middla, Last) 16. Mothar's Name (First, Middla, Maidan Surnama) Harry Seitz Mary 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Ruth MacGill/daughter Box 220, Williamsport, Pennsylvania 197702 20a. Mathod of Disposition

★Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of camatary, cramatory or other place)
Millwood Mennonite Date 20c. Location - City or Town, State June 26 4 ☐ Donation 5 ☐ Other (Specify) 1998 Gap, Pennsylvania Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. ul. 103 West Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Causa (Finat Coronary Artery D. Duer (or as a consadrance of): Diaesse >10 years disease or condition rasulting in death) Examiner Examiner lcian end bunel-trans Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) physician s the buriel Physiclan/Medical Due to (or as a consequence of): 80 use 23b. Did tobacco was contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? has 1 Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Was cesa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Othar (Spacify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28d. Describe how Injury occurred 28b. Time of 1 Naturat 5 Panding invastigation deeth. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide or a 24 hours e 29a. Certifier 12 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 29b. Signatura and title of cartifiar 29c. License number 29d. Date signed (Month, Day, Year) Monte Makons, MD June 24, 1998 D-44783 30. Nama and address of person who completed ceuse of death (Itam 23a) (Type, Print) ELHTON, MD 21921 Ill West High street, MONTE MAKOUS 31. Date fited (Month, Day, Year) 32. Registrar's Signature JUN 2 5 1998 Fulid Davidson Randall Registrar

RLENE

State of Maryland / Department of Health and Mental Hygiene 2 1 0 9 1

						Certific	ate of	Death		Reg. No.	Come	1031
	Physician		1. Decedent's Nama (First, Middla, La	ist)					2. Date of Do Month	eeth Dey	Yeer	3. Time of Death
	/Medical	١.	ERNEST L.						JUNE	4 1998		0940
	Examiner	4	4a Fecility Name (If not institution, give	re street end number)				4b. City, Town, or	Location of Dee	th 4c. County	of Death	
		4	ANNE ARUNDEL M			tabasa Milin	der 1 Yea	ANNAPOL	IS s. 8, Date of Bi			NDEL
	Funeral	1	5. Social Security Number 6. S	Sex 7. Ag 1⊠M 2□F	ge (In yrs. last b	Yrs. Mont			. (Month, D	ay, Year)		place (Stete or Foreign ntry)
	Director	-	217-56-4338 Usual Residence of Decedent		4.7				AUG.	4 1950	MA	RYLAND
	Mond	-	10a. State 10b. County		10c. City, To	wn or Location						10d. Inside City Limits
	Mar Mar		MARYLAND ANNE	ARIINDEI.	ANNA	POLTS						Yos 2□ No
	with the Maryland a or 28a-f show Los northing at		10e. Street and Number				Zip Code			10g. Citizan of V	Vhet Cou	ntry?
	eftar deeth with the Maryler or items 23a or 28a-f show rener must be notified at Funeral Director		130 HEARNE ROA	D APT. 1	011		2140	1		US		
	to deeth		11. Marital Status	12. Was Decedent Armad Forcas		13. Was De if Yes, s	cedent of pecify Cu	Hispanic Origin? (ban, Maxican, Pua	Specify Yas or N no Rican, etc.)	o- 14. Raci Blac	e - Americk, White,	can Indian, , etc.
20			Mever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐X	No	1 ☐ Yes	2 X No	Specify:		Specify	: B	LACK
21215-0020				Year or Dates:	16	e. Decedent's U	Isual Occ	unation		16b. Kind of Bu	ielnese/ir	nduetry
15			15. Decedent's E (Specify only highest gr	ade completed)		(Give kind of life. DO NO	work done	e during most of we	orking	Tob. Kind of Bu	2011100 ar 111	iduatiy
212	iene.		Elementary/Secondary (0-12)	College (1-4or		MAINTE	NANC	E		FAIRWI	NDS	APTS.
	be filed tal Hygin d other event, the		17. Father's Name (First, Middle, Lest)				18. Mothar's Na	ame (First, Middle	e, Meiden Sumem	na)	
/lar	should be filed within and Mental Hygiene. marked other than imatic event, the M		ASHLEY L. D	ANCE				ETH	EL HUN'	Γ		
Maryland	ges 1 end 2 should be filed within t of Health end Mental Hygiene. If item 27 is marked other than or other traumatic event, ma. To Be Comp		19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Addr	ass (Stree	et e <i>nd N</i> um <i>ber or F</i>	Ru <i>rai Rou</i> te Numi	ber, City or Town,	State, Zi	URNIE, MD.
-	1 end 1 Health em 27 i		TIFFANY JOHNSO	N (DAUGH				E SILEN				
ore	of He	1	20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐	Removal from State	ceme	of Disposition (ery, cremetory	or other pi	(ece)	Date	1		
E	Pa Pa		4 ☐ Donetion 5 ☐ Other (Special		ANNA	COLIS	MEM.	GARDEN	5 6/8/	98 ANNA	POL	15, MD.
Baltimore	pemit. Pages 1 end Depertment of Health Important: If item 27 any injury or other tr phce.		21. Signature of Funaral Service Lica	nsee				ress of Fecility E & SON	S MORTI	IARY.P.	Α.	
	00560		Lavy Di	Reese		821	WEST	ST. AN	NAPOLI	S, MD.		01
п			23a. Part1. Enter the disease, or com- shock, or heart tailure. List only	plicetions that cause one cause on each i	d the death. Deine.	o not enter the r	node of dy	ying, such as cardi	ac or respiratory	arrast,		Approximate Interval Between
	Physician			0							1	Onset and Death
100	/Medical Examiner		Immediate Cause (Finel disaasa or condition resulting in death)	. Kes	DIRECTORY	fai	luce					1 hour
						a consequence	of):				1	11 000
	executed in and riel-transit			b. Ray	verse	a consequence	eli X	7				4 044)
Ġ,	cete be executed physician and s the bunel-transit		Sequentielly list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury				01):				1	Years
68760,	2 DO TO		thet initiated events	c	Due to for as	consequence	of):					
	death certificete e attending physical for use as the		resulting in death) Last		OPD						i	years
Box	attendir for use			d	01							10.5
_ 0	v requires that the death ce been signed by the attendi should be detached for use leted by Physician/		Part II. Other significant conditions	contributing to death b	out not resulting	in the underlyin	ng cause g	given in Part t.	23b. Did	I tobacco use co	ntributa	to the cause of death?
P.0	that the red by the detache								1	Yes 2 300	3□ Pro	obably 4 Unknown
Ś	es the digner be d								-		T	
Records,	The law requires cate has been sign page 2 should be									s en autopsy formed?	81	Vere autopsy findings vailable prior to ompletion of cause
ec	2 S a										o	deeth?
H	The page								1 🗆	Yes 2DANO	1	☐ Yes 2☐ No
Vitai	certificate rector, pag		25. Was case referred to medical examiner?	Magaital			10		eath (Check only	one)		
of	Physician: this certific ral director.		1 Yes 2 Ab	Hospital:	-		DUA		1	sidenca 6 Oth		ify)
n	After funer funer		27. Manner of Death 1 ⊅ Avaturel 5 ☐ Pending	28a. Date of Inju (Month, De	y Year)	. Time of Injury M	28c. Inj W	ork? □Yes 2 □ No	280. Describe	how Injury occur	red	
Division	Attending or death. octor: Afte by the fune		2 Accident Investigation 3 Sulcide 6 Could not be	00 - Diago -41-	iury - At homa				28f. Location	(Street end Numb	ber or Ru	ral Route Number,
Ö	after Direction of the bound of		4 ☐ Homicide determined		c. (Specify)	14111, 011001, 141	nory, omo	•	City or T	own, State)		
	No Hospital or Attending P n 24 hours after death. Funeral Director: After the pletely filled in by the funeral edical Certification:		29a, Certifier Certifying Pt	hysician: To the best	of my knowled	ge, deeth occur	red at the	time, date end plac	ce, and due to the	e cause(s) end me	enner as	stated.
	• Hod 124 h		(Check only 2 Madical Examone)	miner: On the basis of and manner st	f examination (end/or Investiga	tion, in my	opinion, death occ	curred at the time	, dete and placa,	and due	to the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com		29b. Signature and title of continer	1	-			nse number		29d. Date signe	d (Month	, Dey, Year)
			1 then	(D	3549	4	6/	4/9	8
		;	30. Name and address of person who	completed cause of	death (Item 23s	(Type, Print)						
			STEVEN RESNICK	600 RI	DGLEY	AVE.	SUIT	E 121 A	NNAPOL	IS,MD.	214	01
	State		31. Date filed (Month, Dey, Year)	. 0	rar's Signeture	· .						
	Registrar		JUN 0 9	1998	ha Davids	n-Randel	2					



State of Maryland / Department of Health and Mental Hygiene

	_											g. No.		
Physician	_	Decedent's Name (First, N	fiddle, Las	it)							ete of Deeth fonth	Day	Year	3. Tima of Death
/Medical	-	HAZEL MA	ARGAR	ET	HEWITT	DE	WEES			JU				2:55 A
Examiner	_	4a. Fecility Neme (If not instit	lution, give	street end nu	ımber)				4b. City, Town,	or Locatio	n of Deeth	4c. County	of Deeth	
	ı	CITIZEN'S NU	JRSIN	G HOME					FREDERI	CK		FREDE	ERICK	
uneral		5. Sociel Security Numbar	6. Se		7. Age (In)	rs. last birthd	by) If Und Month	der 1 Yaer	If Undar 24 H		ate of Birth Jonth, Dey,			lece (Steta or Forei
irector		217-42-8992 Usuel Residence of Decedan		□M 21√ F	8	7 Yrs	MOTH	is Deys	Hours M		ch 21			
8 m		10e. Stete 10b. Co	unty		10c.	City, Town or	Location						1	0d. Inside City Limit
the de proto	o M	Maryland Fre	ederi	ck	T	hurmon	t							1□Yas 2□N
or 28a-fe be notifies Director		10e. Street end Number					10f. 2	Zip Code			10	g. Citizen of	Whet Coun	ntry?
r Hems 23a	0	8819 Orndorf	Road					1788						
here in the control of the control o		11. Marital Stetus		Armed F	edent Ever in orces?	1 U,S. 1	Was DecIf Yes, sp	cedent of I pecify Cub	Hispenic Origin? ean, Mexican, Pu	(Specify) erto Ricar	ras or No-			
, a d	2	1 Never Merried 2		1 ☐ Yes If Yes, G Yeer or [Specify:					
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Item	#10b per FH (3762 8/4/98		Marylan		irtment of F tificate of	Health and Death	Mental Hy	giene Reg. No. 98	21	093
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Examine	4s Facility Name						4b. City, Town, or	Location of Deat	th 4c. County	of Death	
Funeral	5. Social Security 1 220 – 28 –		MORIAL Sex 1 M X F	7. Age (In yrs. I		If Under 1 Year Months Days	FREDER I If Under 24 Hrs Hours Min.	8. Date of Bi (Month, Di NOV .	FREDI	9. Birthplac	ce (Stete or Foreign
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vith the Mar	MD.	CARROI	Frederic	K .	MT. A	10f. Zip Code			10g. Citizen of W	That Country	
with with	4440 M		TOM ROA	AD			771		U.S.		
5-0020 72 hours after death with the Manyland neturel", or thems 23e or 28e-f show other forms the notified.	11. Marital Status 1 Never Marital Status 3 XWidowed	ried 2 Married	12. Was Deced Armed For 1 Tyes If Yes, Give Year or Da	dent Ever In U, ces? 2 X No		Vas Decedent of I I Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	Black	BLAC	3.
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/Medical Examiner	Immediate Ceuse disease or conditi- resulting in death)	on	a. Acı		M 40 or as a consec	quence of):	Into	ration		3	30 min
Box 68760, ath certificate be executed attending physician and for use as the bunel-transit	Cause (Disease of thet Initiated event resulting In death)	5	c		r as a conseq						
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or with	29b. Signeture end	a title of certifier	-			29c. Licen	1944		29d. Date signed	S 9	ly, Year)
	30. Name and add	ress of person who		of death (Item		Print) NTH ST.	FREDER	TCK MD	. 21701		
State Registrar	31. Date filed (Mor	nth, Day, Year)	20 De	gistrar's Signal	turo		FREDER	TCK MD	. 21/01		

DHMH 16 Ray 6/95

AMENDED LINE 8 6/15/98
LBURNS FCHD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 21094

					Cel	runcau	e or	Death		Reg. No.	-	-105		
		1. Decedent'a Neme (First, Middle	, Last)						2. Dete of De	eth Day	Yeer	3. Time of D		
Physic /Medi		Marci	la Gall	iher	Da	У			June	4	1998	11:50		
Exami		4a. Facility Name (If not institution	, give street and numbe	r)			-	4b. City, Town, or I		4c. Cou	nty of Death			
		Suburban Ho	snital					Bethesda		Mon	ntgome	rv		
Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs.	lest birthday)	If Under Months	1 Year Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir			pleca (Stete or F		
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P.		Usuel Residence of Decedent												
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a di	ct		gomery	В	ethesd	a				↑ Yes 2				
or 2	Director	10e. Street end Number				10f. Zip				10g. Citizen	of What Cou	ntry?		
23.0	-E	5603 McLean Dri	ve				208	314		U.S.	.A.			
Hygiene. Hygiene. The Medical Examiner must and, the Medical Examiner must be	Funerai	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U ?	J,S. 13.	Was Deced	ent of H	lispanic Orlgin? (S en, Mexican, Puert	pecify Yes or No o Rican, etc.)		Race - Ameri Bleck, White			
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r heatn and Mental hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-f aho other traumatic avent, fre Medical Examinet must be notified at		19e. Informant's Name/Reletionsh				_		end Number or Ru						
Department of Health and Mental thysiene. Important: If item 27 is marked other than any injury or other traumatic avent, the Me once.		Carol L. Meller	1 - Daugnte		Plece of Dispo			Ebbs Lane						
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()	Be	25. Was case referred to medical examiner?						26. Plece of Dec	oth (Check only	one)				
clor	0	1 ☐ Yes 2 No	Hospital: 1 Hopa	tient 2	ER/Outpetier	nt 3□ DO	A Oth	ner: 4 Nursing H	ome 5 Resi	denca 6 □0	Other (Speci	(fy)		
nis certificate he I director, page	15-	27. Manner of Deeth 1 Netural 5 ☐ Pending	28e. Dete of In (Month, D	jury lev Year)	28b. Time of	f 2	Bc. Injur Wor	y et rk?	28d. Describe	how injury occ	curred			
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #23 PART I, PER PHYSICIAN G767 1-4-9 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death 2. Data of Deeth **Physician** Thomas J. Dorr, Sr. 1998 4:20 p.m. June /Medical 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Prince George's 2409 57th Place Tuxedo If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. lest birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days 1₩ M 2□ F Months Yrs. 83 January 30, 1915 Washington, D.C. Director 579-01-9400 Usual Residence of Dacedant with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Vas 2 □ No Directo Prince George's Tuxedo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or itema 23a or interpretain and proce. 20785 U.S.A. 2409 57th Place Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Yes 2 No If Yas, Give Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: Specify: White by 3 N Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Collega (1-4or 5+) Elamantary/Secondary (0-12) Automobile Mechanic Mechanic 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Elizabeth O'Flarity August Dorr 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 3391 Horsehead South, Laurel, Maryland 20724 Lawrence C. Douglas -Step-Son 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 6/22/98 Alexandria, Virginia Metropolitan Crematory 22. Name and Addrass of Facility
Gasch's Funeral Home 21. Signetura of Funeral Service Licenses 4739 Baltimore Avenue, Hyattsville, MD. 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one cause on each line. Approximata Intarval Between Onset and Daath **Physician** Immediata Causa (Final disaesa or condition resulting in death) /Medical Non-Small call Carringer of years Examiner Examine Dua to (or as a consequence of): and I-transit the daath certificate be executed Sequantially list conditions, if eny, leading to immadiata causa. Enter Undarlying Cause (Disease or Injury nding physician a use as the burial-Division of Vital Records, P.O. Box 68760, Excloso vascular Physician/Medical that initiated avents rasulting in daath) Last Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown Chronic Subler þ 24b. Wara autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy performed? Chronice alished about 7 40 yrs. irector, page 1 Yas 2 No 1 ☐ Yes 2 No 25. Was casa rafarred to medical axaminar? Be 26. Piece of Deeth (Check only one) To Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) funeral 27. Menner of Death 28a. Data of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of after death. Director: After t Certification: Naturai 2 Accidant 5 Panding invastigetion 1 ☐ Yas 2 ☐ No 6 Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicida 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 6 4 T Homicida ò filled in 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated. 29a. Cartifier edicai (Check only one) To the To the To the 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signatura and title of certifier repto MO D20727 30. Nama and address of person who complated causa of daeth (Itam 23a) (Type, Print)
RENULA GUMB 7215-D HANOVER PARKWAY GREENBELT MD 20170 10

DHMH 16 Rev 6/95

Registrar

31. Data filed (Month, Dey, Yeer)

JUN 22 1998

32. Registrer's Signeture

This objection hardell

		State of Marylan		ent of He ate of D			giene Reg. No.	8 2	1096
Physician /Medical	Decedent's Neme (First, Middle, Las		rham			Month			
Examiner	4s Fecility Neme (If not institution, give	street end number)		4b	. City, Town, or L	ocation of Deet	4c. County	of Deeth	
	Pineview Nursing				Clinton			e Geor	~
Funeral Director	379-30-7000	7. Age (In yrs. ☐ M 2 ☐ F 94	Yrs.	ths Deys	Hours Min.	8. Date of Bir (Month, De May 24			ce (Stete or Foreign y) Virginia
and w	Usuel Residence of Decedent 10a. Stete 10b. County	10c. Cit	y, Town or Location					100	d. Inside City Limits
Mary February Tor	Maryland Prince G	George's	Temple Hi	11s					1 ☐ Yes XX No
vith the Marylar or 28s-1 show be notified.	10e. Street and Number		•	Zip Code			10g. Citizen of	What Countr	y?
P with	6207 Delbarton St			20748			U.S.	Α.	
uref, or items 23s or 28s-f show at Examiner must be notified at the by Funeral Director.	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		v.	spenic Origin? (Sp., Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Bla	ca - American ck, White, et y. White	lc.
ygiene. her than "naturel", rt, the Medical Exa Completed by	15. Decedent's Edi (Specify only highest gred	ucation	16e. Decedent's	Jsuei Occupat	tion uring most of work	cina	16b. Kind of B	usiness/Indu	istry
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sumetic To	Bruce E. Martin 19e. Informent's Neme/Reletionship (7)	ima Briath	10h Mailing Add	ross /Stmoto	Mary S		or City or Town	State Zin (Parial
프릴	Doris Eggleston/I		-		n St. Te				
tiem 27 is marked other than other traumatic event, the M To Be Comp	20e. Method of Disposition		Plece of Disposition ametery, cremetory			Dete	20c. Location		
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eny injury or other tr	21. Signature of Funeral Service Licens		22. Nam Geor	e end Address ge P.	9	neral H	lome, P.	Α.	
of by the attending physician and sected for use as the burial-transit arising the physician/Medical Examiner	23a. Pert1. Enter the disease, or compshock, or hand failure. List only of limits of the disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	. Renal Fa Orteriose Due to (c Methaulle		of): Dubro of): Sh		ear l	nseas tis		nfervel Between Onset and Deeth
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rector, page						10	Yes 2 No	10	Yes 2□ No
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	1/ Alle Con	maughe	1 CM	007	287		6/	22/	128.
)	30. Name end eddress of person who c			on Rd.	, Ft. Wa	shingto	on, Md.2	0744	
State	31. Dete filed (Month, Dey, Year)	32. Registrer's Signe	ture						
Registrar	JUN 22 199	8 Jelli Much	or Randall						

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				Certificate of	Death	Reg	g. No.	0 2	1097		
Physi	ician	Decedent's Name (First, Middle, L. Clarence	1	iels		Date of Death Month	Day	Year	3. Time of Death		
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anylen show	5			ity, Town or Location				10d.	Inside City Limits 1 √2 Yas 2 □ No		
the A	Director	District of Colu	IMD1a	Washington 10f. Zip Code		10	10g. Citizen of What Country?				
with with			treet, S. E.		0020		Jnited				
death me 2	Funeral	11. Marital Status	12. Was Decedent Ever in		lispanic Origin? (Specify en, Mexican, Puerto Ric						
21215-0020 d within 72 hours effer death with the Manyland glene. It than "natural", or itams 23a or 28a-f ahow than Wed call Examiner must be notified at	by Fur	1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed Forces? XXYes 2 No Oc If Yes, Give Year or Dates:Jan.	t.1943	en, Mexican, Puerto Rici Specify:	en, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: Black				
72 hours	b B	15. Decedent's E	ducation	16a. Decedent's Usual Occup	pation	try					
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other tr		Susie Lucille E1 20a. Method of Disposition		Place of Disposition (Name of	T	.E.; Washington, D.C. 200 Date 20c. Location - City or Town, St					
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Baltimo permit. Page Department Important: If any Injury or	ů.	21. Signature of Funeral Sarvice Lice				Quantico, Virginia rt G. Mason Funeral Home, I					
Balt permit. Departr Importr any Inju		1661 Good Hope Road, S. E.; Washington, D.C.									
		23a. Part1. Enter the disease, or conshock, or heart failure.	indications that ceused the dea	ath. Do not enter the mode of dylr				-	proximate		
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death certi	ician/M	Part II. Other significant conditions of	contribution to death but not rea	culting in the underlying eques of	ton in Dort i	22h Did toh		abellación do da	e cause of death?		
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0 0	Completed b	My o carela Chromz Obst	1 Infava	NON		24a. Was an performe		avalla	autopsy findings ble prior to ietion of causa		
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		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Qay Year)	28b. Time of 28c. Injury Wor	y at 28d	. Describe how	Injury occurr	red			
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To the Ho within 24 I To the Fu completel		30. Name and address of person who	completed ceuse of death (ite	2 20	1852			17,10	98		

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by Funeral Director	3 🔯		ed 2□ Man	rried	2. Wes Decede Armed Force 1 Yes 21 If Yes, Give Year or Dete	es? ☑ No	l,S. 13	i, Was Dece If Yes, sp 1 ☐ Yes		dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		Bleck, White	, etc.
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			Maryland		ificate of	Death		Reg. No. 98	21099
Physician /Medical	1. Decedent's Name (First, M Janice	C •	East				2. Date of Do Month June	Day	3. Time of Death 7:30 AM
Examiner Funeral Director	4a Facility Name (If not Institute 8150 Lakecre 5. Social Security Number 253–80–9378	est Dr. # 6			If Under 1 Year Months Days		1t s. 8. Date of Bi	Prince	Deeth Decrees Second State or Foreign Country Alabama
Meryland H show fied at	Usual Residence of Deceden 10a. Stete 10b. Cou		10c. City	, Town or Loca	ation				10d. Inside City Limits
notified netfector	Maryland Pri	nce Georges		Greenbe	lt				1 ∕ es 2 □ No
	10e. Street and Number	-t D- # 61			10f. Zip Code	770		10g. Citizen of Wh	
tramper must by Funeral	8150 Lakecres 11. Marital Status 1 Never Married 2X 3 Widowed 4 Divor	12. Wes Dece Armed Fo 1 Yes	edent Ever in U,S rces? 2010 /e			770 Hispanic Origin? (pan, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	U.S.2 o- 14. Raca Black Specify:	A. - American Indian, White, etc. White
Completed b	15. Dece	edent's Education ghest grade completed)				pation during most of w od) Operator	orking	16b. Kind of Bus	
Be Co	17. Father's Name (First, Mid	Idle, Last)		101	Срионе		erne (First, Middle	Unk. e, Maiden Sumame)
To B	J.T. Brown					Elois	e Strick	land	
raumatic ev	19a. Informant's Name/Relat Jake C. Eas		, be					ber, City or Town, S	
ant: If Item 27 ury or other 1	20a. Method of Disposition 1 □ Burial 2 ▼Cremati 4 □ Donation 5 □ Othe	ion 3 Removel from	20b. Pla	lace of Disposit		100)	Date	20c. Location - C Alexand	City or Town, State
importa any inju pnce.	21. Signature of Funeral Sen	vice Licensee	1-	22.1	Neme and Addr Rendon/1 013 And	ess of Facility Hale Fun napolis	eral Hom Rd. Lanh	ne nam, MD 20	0706
e ettending physician end and for use es the burial-transit and for use es the burial-transit and for use estimated and for use and for us	disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	a. /y b. /y cS/	Due to Cor	as a conseque	ence of):	trops	reali	nea	18 9Rs iput >59 ×5 4RS
beched	Part II. Other significant con	an ex 4e	eath but not resu	alting in the und	lerlying cause g	iven in Part I.		1	ribute to the cause of death?
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Medical Certification:	3 ☐ Suicide 6 ☐ Co	termined 28e. Plece buildi	of Injury - At hor ng, etc. (Specify)	me, farm, stree	et, factory, offica			(Street and Numbe own, State)	r or Rural Route Number,
he Funera pletely fillic edical (29a. Certifier Certifier (Check only one)	ifying Physician: To the lcal Examiner: On the band man	best of my know asis of examinati ner stated.	vledge, death o ion and/or inve	occurred et the t stigation, in my	ime, date and ple opinion, death oc	ce, and due to the curred at the time	e ceuse(s) end man , date and place, se	ner es stated. nd due to the cause(s)
To the	29b. Signature and title of	rilier			29c. Licen	se number		29d. Dete signed	(Month, Day, Year)
	///m	famme	m	0	1)-	1082	1	6/20	198
5/	30. Name and address of Ger	Toucian	943	o Fe	nn-Av	e.#18	Maple	e Mer	Iboro,
State Registrar	31. Date filed (Month, Day, Yo	(ear) 32. R	egistrer's Signati	re Carl II				h	20172

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 18 ARCHIE **FDWARDS** 1998 10:54 PM June /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1151 Booker Drive Seat Pleasant Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) **Funeral** 1X0 M 2□ F 79 Yrs. 287-14-9153 September 4, 1918 Virginia Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at with the Marylei 1 Yas 2 □ No Directo Maryland Prince George's Seat Pleasant 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1151 Booker Drive 20743 U.S.A. Funeral death permit. Peges 1 and 2 should be filed within 72 hours after death Department of Health end Mentel Hygiene.
Important: If flem 27 is marked other thems any Injury or other traumer. 12. Was Decedent Ever In U.S. Armed Forcas? 1 1⊠ Yes 2 □ No 3/21/41 If Yes, Give Year or Datas: 1/16/46 14. Race - Americen Indian, Black, Whita, etc. 11. Maritai Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🛛 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Security Officer Government 7th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) Roy Edwards Pearl Spencer 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 19a. informant's Name/Relationship (Type, Print) 1151 Booker Drive, Seat Pleasant, Maryland 20743 Frances Edwards/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 06/24 1998 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses Percen-7474 Landover Road, Landover, Maryland 20785 23a. Part1. Entar the disease, or complications that causad tha daath. Do not enter tha mode of dying, such as cardlac or respiratory arrest, shock, or heart feilure). List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician and the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequenca of): 980 signed by the a Part It. Other significant conditions, contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceuse of deeth? Completed 24a. Was an autopsy performed? hes 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital f or Attanding Physicien: efter deeth. Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 10 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide A Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) To the To the To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licanse number Bevery He got md 32 Registrar's Signature Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First Middle Last) 2. Dete of Deeth Month David Lewis Ewing June. 1998 5:20 AM 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Harford Memorial Hospital Havre de Grace Harford 5. Sociel Security Number if Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, 1 NOV. 13, 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 10XM 20 F Devs Yrs 212-50-2845 51 1946 Maryland Usuel Residence of Deceden 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Cecil Rising Sun 10e. Street end Number 10f. Zip Code 10g. Citlzen of Whet Country? 395 Biggs Hwy. 21911 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 (X)Yas 2 □ No If Yas, Giva Year or Detes: 1970-71 11. Maritai Stetus Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Navar Married 2 Marriad 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Accounting Accounting 17. Fethar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Surname) David E. Ewing Gaynell McGlothlin 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) Susan Ewing/Wife 395 Biggs Hwy. Rising Sun. MD 21911 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 A Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) A. Ferris & Co., Inc. 6/28/98 West Chester, PA R. T. Foard Funeral Home, P. A. 21. Signature of Fulleyal Service Licensee 111 S. Queen St. ue Rising Sun, MD 21911 Maro Mal caused the deeth. Do not enter tha moda of dying, such as cerdiac or respiretory errast, or aach line. Approximate Interval Batween Onset end Death er the diseese, or complications theart feilura. List only ona ceuse Immadiata dause (Finel Ihr. diseasa or condition resulting in daath) myocardial Due to (or es e consaquance of): artery, disease Coronary Sequentially list conditions, if eny, leading to immadiate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Dua to (or es e consequence of) elevated cholesterol + triglycerides Due to (or es e consequence of): Pert ii. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings aveilebla prior to completion of cause of daeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes cesa rafarrad to medical examiner? 26. Place of Deeth (Check only one)

Physician /Medical **Examiner**

permit. Page Department of Important: If any Injury or once.

Physician

Examiner

Funeral

Director

28a-f ahow must be notified at

items 23a

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. Pages 1 and 2 should be filment of Health and Mental Hant: If Item 27 is marked oth jury or other traumatic even

traumatic event, the Medical Examiner

Directo

Completed by Funeral

Be

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death

filed within 72 hours after

21215-0020

Baltimore, Maryland

P.O. Box 68760,

Division of Vital Records,

/Medical

10e State

and

Examiner Physician/Medicai Completed by Be 2 Certification:

The law requires that the death certificate be executed ata has been signed by paga 2 should be detac or Attending Physician: After this death. after death Director: in by t within 24 hours a To the Funeral C

6+1 VA

State Registrar

Medicai

Oliver S. Thresher Jr. 31, Dete filed (Month, Dev. Year)

1 Yas 2 No

27. Manner of Deeth

1 Meturel

2 Accident

3 Sulcide

29e. Certifiar

4 Homicide

29b. Signeture end title of certifier

MD PO Box 848 32. Registrar's Signetura

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetiant 3 ☐ DOA

28b. Tima of

28e. Plece of Injury - At home, ferm, straet, factory, office building, etc. (Specify)

D-33925

12 Certifying Physician: To the best of my knowledge, death occurred et the tima, data and piece, end due to the cause(s) end manner as steted.

2 Medical Exeminer: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at tha time, date and place, and due to the cause(s) end menner stated.

29c. License number

28c. Injury et Work?

1 ☐ Yas 2 ☐ No

29d. Dete signed (Month, Dey, Yeer)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Othar: 4 Nursing Home 5 Residence 8 FOther (Specify) Memorial

28d. Describe how injury occurred

Harford

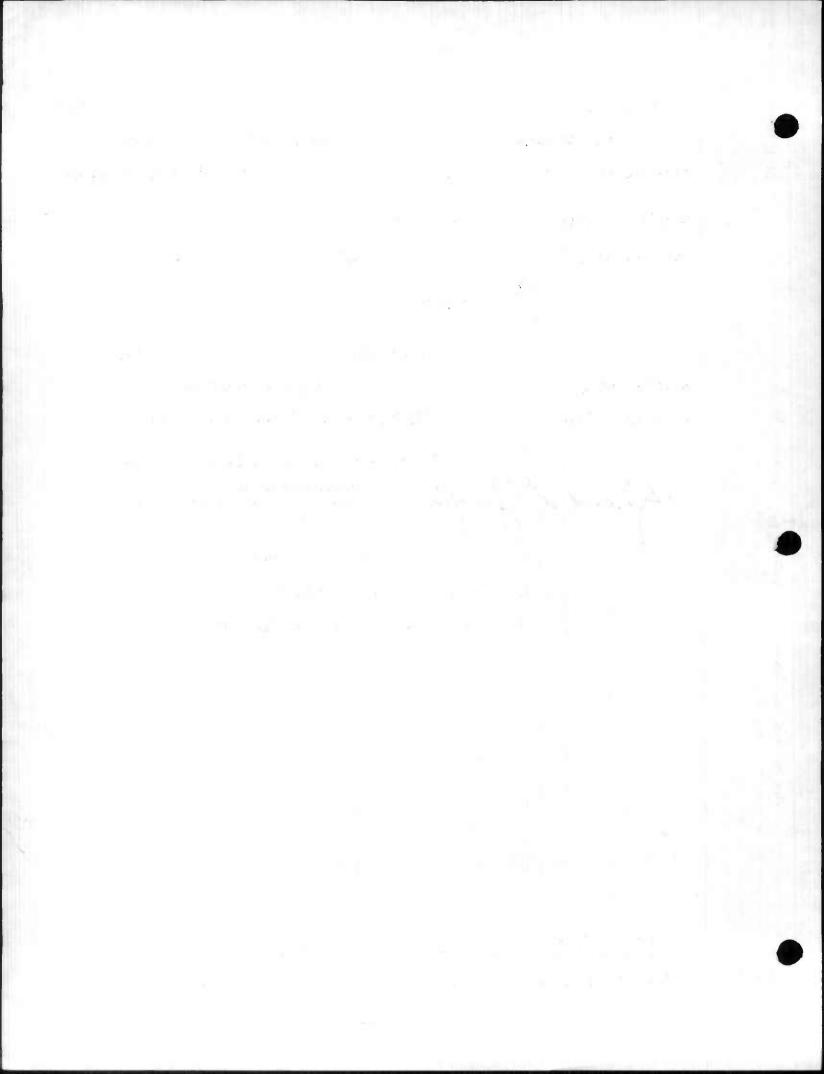
30. Name end address of parson who complated cause of death (Itam 23a) (Type, Print) Rising Sun, MD 21911

28e. Dete of Injury (Month, Dey Year)

JUN 2 9 1998

5 Pending Investigation

6 Could not be determined



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Day **Physician** 1003 1998 James Leroy Fo1ks LINE /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner SHADY GROVE ADVENTIST ROCKVILLE MON
If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year)
August 1, 1938 HOSPITAL MONTGOMERY 5. Sociel Security Number if Under 1 Year Birthplece (Stete or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) **Funeral** Months 110 M 2□ F Deys Yrs. 59 Director 218-34-5782 Usuel Residence of Deceden permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f show 10d. Inside City Limits 10c. City. Town or Location 10e State 10b. County r 28a-f ahow 1 Yes 2 No Director Montgomery Gaithersburg Maryland 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? "natural", or items 23s or solical Examiner must be 20882 U.S.A. 24129 Bush Hill Road Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerlo Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married 1 Yes 2X No Specify: Specify. à White 3 ☐ Widowed 4 ☑ Divorced or then neture. Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Contractor Electrician 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Blanche Hamilton Fo1ks Lee 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 24129 Bush Hill Road, Gaithersburg, Maryland Audrey W. Hill - Daughter 20c. Location - City or Town, State 20882 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Important: If its any injury or o 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 6/18/98 Alexandria, Virginia Metropolitan Crematorium 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fune 22. Name end Address of Fecility Service Licensee Olin L. Molesworth, P.A., Funeral Home 23a. Part Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock or man failure. List only one ceuse on each line. 20872-0117 Approximate intervel Between Onset and Death **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical SHOCK Examiner Due to (or as a consequence of) Physician/Medical Examiner UNDSEPSIS ettending physician and for use es the bunal-trensit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? ESDIRATORY FAILUME signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? HEPATIC ENCEPHACO PATITY Completed peed hes 90ed 1 ☐ Yes 2 No 1 ☐ Yes 2 No this certificate Be 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Naturel 5 Pending Investigation death. 1 Yes 2 No hin 24 hours after death.

the Funeral Director: A
npletely filled in by the fu 2 Accident 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 29e. Certifie edicai (Check only within 2

29d. Date signed (Month, Dey, Year)

1)30112

State Registrar

altimore, Maryland 21215-0020

The lew requires that the death certificate be executed

Hospital or Attanding Physician:

Division of Vital Records, P.O. Box 68760,

VINENDRA K. SAKENA 31. Dete filed (Month,

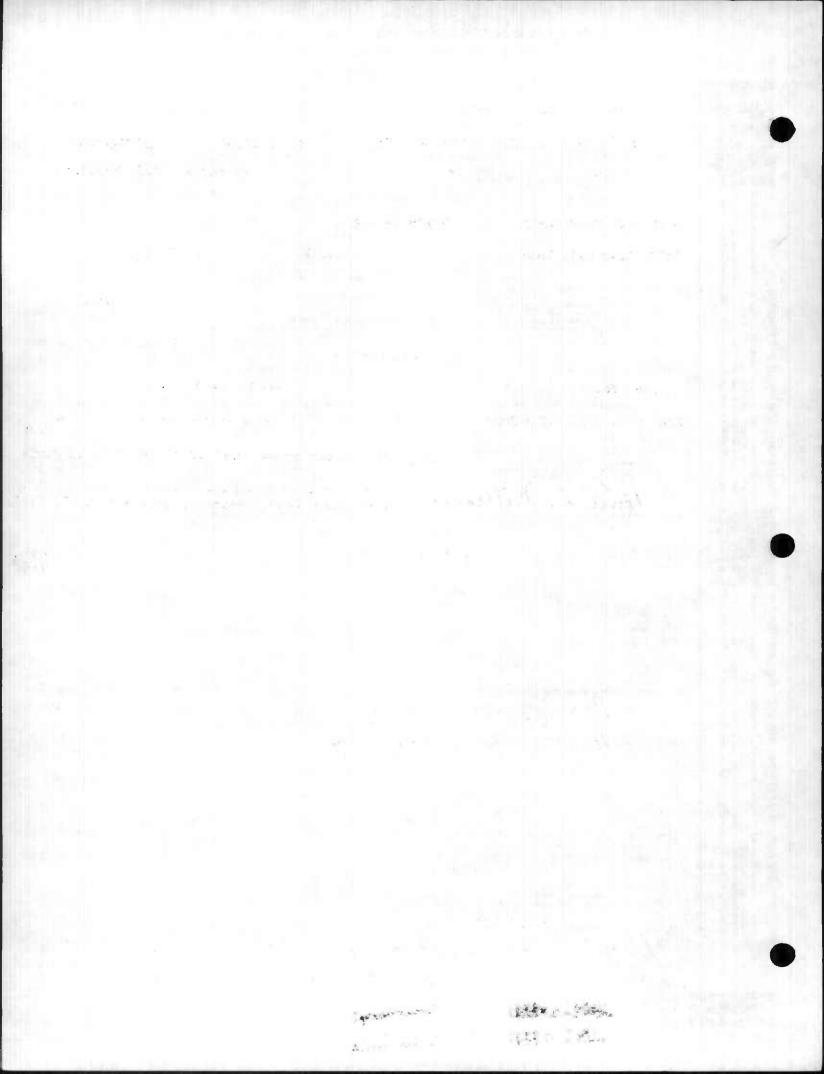
DHMH 16 Rev 6/95

29b. Signature

32. Registrar's Signature.

CALITICAL CARE CONSKOTANI 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

VINEW DRA K. SAKEMA 7100 DEER CROSSING COURT, BETHESDA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2 Date of Death 3 Time of Death **Physician** Month TzgerAld 2:20 pm Elizabeth HARRIET ELIZAL a. Facility Name (If not institution, give street and number /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 109 BOOTK 5. Sociel Security Number 6. STREET EIKTO If Under 24 Hrs. 7. Aga (In yrs. lest birthday) If Under 1 Year 6. Sex 8. Date of Birth (Month, Day, Birthplaca (Steta or Foreign Country) 212-38-4296 Usual Rasidenca of Decadant 1 M 2 F Months Deys Hours Min. 96 Yrs. MARYIANd ca of Decadant 10b. County 10e. Stata 10c. City, Town or Location 10d. insida City Limits **Funeral Director** MD 1 Yes 2□No 10a Street and Number 10f. Zip Code 10g. Citizan of What Country? STRee U5A 2 10 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 2 No tf Yas, Giva Yaar or Detas: 11. Marital Status 14. Race - American Indien, Black, White, atc. 1 Navar Married 2 Marriad 1 Yas 2 No Completed by Specify Specify: BIACK 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highast grade complated) 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) TEAChe EduCATION 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be AROMIA MILBUYN 2 OhNSON 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2/20 9 BA/timbre pr 20c. Location - City or Town, Stata -Ober TSON 20b. Placa of Disposition (Nama of cametery, cramatory or other piece) OUTT-20e. Mathod of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) EIKTON, MU Cometery 22. Nama and Address of Facility CON 90 21. Signatura of Funarai Sarvice Licer FUNERAL HOME 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each limit Wilm, De 19805 Approximata Intarval Batwe Immediata Causa (Final congestive heart disaase or condition resulting in death) wonay Artery Disease Dua to (or as a consequence of): Sequantially list conditions, if any, leading to Immadleta cause. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in death) Lest Due to (or as e consaquance of) Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Vinknown hypertension à Completed 24b. Wera autopsy findings evelleble prior to complation of causa of death? 24a. Wes an autopsy performed? aremia 1 ☐ Yas 2 DW6 1 ☐ Yes 2 ☐ No Be 25. Was casa raferred to medical 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Assidance 6 Othar (Specify) Certification: To

Examiner The law requires that the death certificate be executed pue attending physician for use as the burie Physician/Medical After this certificate has been signed by the funeral director, page 2 should be detached

Funerai

Director

Show

r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at

Pages 1 and 2 should be filed w tracent of Heelth and Mental Hygies tant: if item 27 is marked other ti lury or other traumstic event,

permit. Pages 1 and 2. Department of Heelth at Important: If Item 27 is any injury or other trau

Physician /Medical

Examiner

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

To the

within 24 hours after death To the Funeral Director: A

filled in by the

Medical

filed within 72 hours efter death with the Maryland

Baltimore, Maryland 21215-0020

1 Yas 2 No

5 Panding

investigation

6 Could not be datarminad

28a. Data of Injury (Month, Day Year) 28b. Tima of fnjury NIA NIA

28c. Injury at Work? MIA 1 Yes 2 No

28d. Dascribe how Injury occurred

NIA

28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29e. Cartifian

27. Manner of Death

1 Natural

2 Accidant

3 Suicida

4 Homicide

28a. Ptace of Injury - At homa, farm, straet, fectory, offica building, atc. (Specify) 1 Certifying Phyalclan: To the bast of my knowladga, deeth occurred at tha time, deta and placa, and dua to tha cause(s) end mannar as stated.

2 Madical Examiner: On the basts of axamination end/or invastigation, in my opinion, death occurred at the time, deta end place, and due to the cause(s) end mannar stated.

29d. Data signed (Month, Day, Year)

29b. Signeture end titla of certifier marie Paylomo 29c. License number DS0195

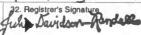
June 20, 1998

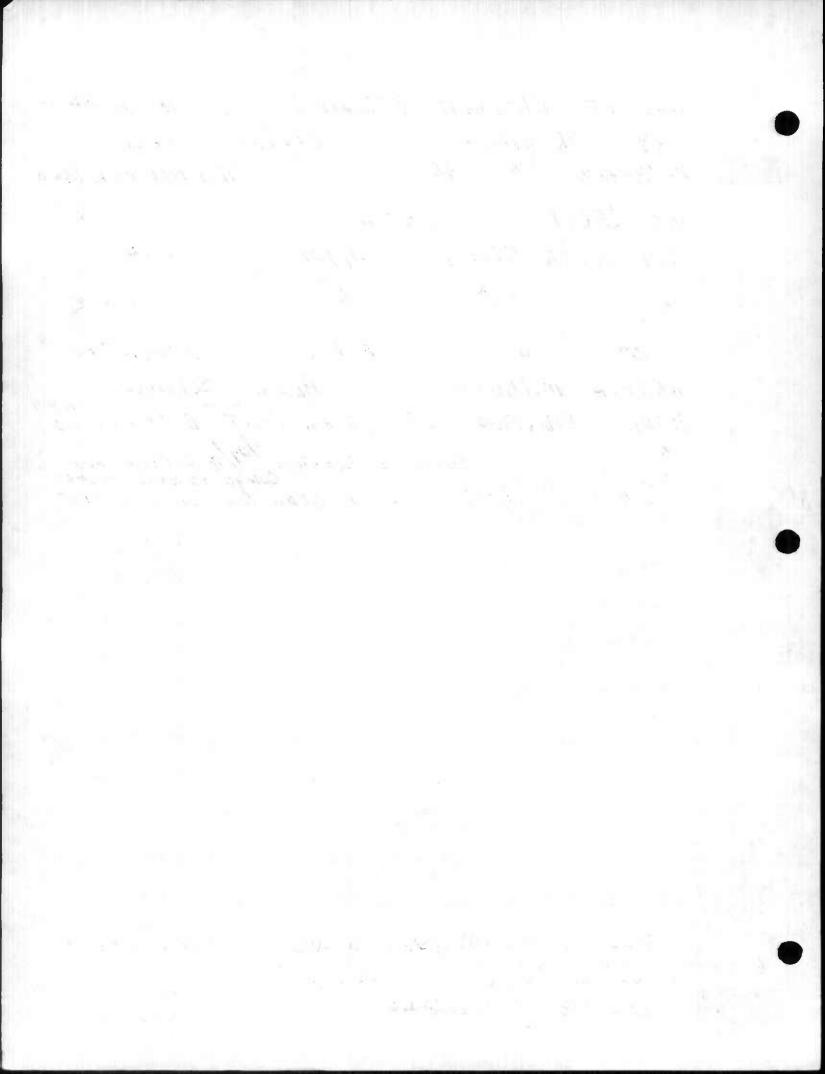
30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

101 colonial way Sun, MD 21911 Risins

State Registra

31. Data filed (Month, Day, Yaer) JUN 2 5 1998





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Daath 3. Tima of Death Month J428 28 FOLAN DOROTHY ALICE 2121 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, giva street and number) 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Hours Min. 8. Data of Birth (Month, Day, Year) 9. Birthplace (Stata or Foraign Country) SEPT. 30,1918 WASHINGTON, DC If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Months 1 M 200 Days 79 579-14-6415 10c. City, Town or Location 10a Stata 10d. fnsida City Limits 10b. County VIRGINIA **ACCOMACK** CHINCOTEAGUE 1 XYas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? U. S. A. 4210 DIVISION STREET 23336 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedanf of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amaricen Indian 11. Merital Status Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 TNo Specify: Specify: WHITE 3 NWidowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5+) AT HOME HOME MAKER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) ALICE R. DANIELS THOMAS G. WOODS 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 4059 SUNNYWOOD DRIVE CHINCOTEAGUE, VA 23336 LOUIS M. HESEN / SON 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata TIPEY Burial 2 Cremetion 3 Ramovel from State 1,1998 SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) CEDAR HILL CEMETERY 22. Nama and Addrass of Fecility LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND INT.I. Enter the disable, or complications the caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Requestry Fally tmmediata Causa (Final diseasa or condition resulting in daath) Swere LOPD = Chani Hyporentilation Sequentially list conditions, if eny, leading to immediata ceusa. Entar Undartying Causa (Disaasa or injury that initiated evants resulting in daath) Last Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 3 Probably 4 Unknown 1 Yes 2 No Anton Drain with near PTVA Dr 24b. Ware autopsy findings evailable prior to 24a. Was an autopsy performed? Parangonal Africal Flullations complation of ceusa of death? 1 Yas 2 No Insulia Ry 1 Yas 2 No 25. Was cesa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yas 2 No 28a. Dala of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1. Natural

Physician /Medical Examiner

Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at

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Department of h Important: If ite

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physician end the buriel-trans USB signed by t d be detect this

Division of Vital Records, P.O. Box 68760, after death. Director: Aft 0

Hospital 24 hours a 24 hours

To the within 2

Physician/Medical þ Completed Be 9 Certification:

> State Registrar

Medical

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

ginocular.

28a. Place of Injury - Al homa, farm, streat, factory, office building, atc. (Specify)

1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.
2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred of tha time, date and place, and dua to the cause(s) and mannar stated. 29c. Licanse number

6 Could not be dataminad

2 Accidant

4 Homicida

(Check only one)

J 85684

29b. Signetura end fitle of certifian

3 Suicida

29a. Certifier

MILLOW

1 ☐ Yas 2 ☐ No

29d. Date signed (Month, Day, Year) 6.2998

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

MS

SAUSO-AT MY 21304

31. Data filed (Month, Day, Year) 32. Registrarie Signatura JUL 01 1998 Folis Saveton Randall

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 21105

29d. Data signed (Month, Day, Year)

Physicla	_	1. Decedent's Name (First, Middle, Les Robert 1	A. GIGAN	Ti			2. Date of D	Day	19690	3. Time of Deeth
/Medica Examine		4a. Facility Neme (If not institution, give	street end number)			4b. City, Town, or	Location of Dea	th 4c. Count		NEDY
Funeral Director		5. Social Security Number 6. S 579-70-6747	PSBACK WA PX MM 2 F 7. Age (In yrs. In MM 44	est birthdey) Yrs.	If Undar 1 Ya Months Dey	ar If Under 24 Hrs	(Month, E	irth		MERY ece (Stete or Foreign ry) yland
how		Usual Residence of Decedent 10e. State 10b. County	10c. City	, Town or Lo	cation				10	d. Inside City Limits
death with the Maryland	Director	Maryland Montgo	mery Dam	ascus	10f. Zip Code			10g. Citizen of	What Count	1 ☐ Yes 2 ☑ No
23a or		9936 Canvasback V	lav		2087			Unite		
al', or its	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decadent Ever in U,s Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	11		f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or N to Ricen, atc.)		ce - America ck, White, a	en Indien, itc.
ene. than "natural", ne Med cal Exp	Completed	15. Decedent's Ed (Specify only highast gra Elementary/Secondary (0-12)	ucation de completed) Coilege (1-4or 5+)	(Give I lifa. D	OO NOT use reti	e during most of wo	rking	16b. Kind of B		ustry
to b	Be	17. Fathar's Name (First, Middle, Last)	2	58.	lesman			Hard e, Meiden Sumar	The Part of the Pa	
mark matic	9	Vincent Giganti 19a. informant's Name/Rejetionship (7)	vne Print)	19h Mailin	n Addrace /Stre	Patric:	ia McClo		State 7in	Codel
If Item 27 is or other trau		Brian Giganti/ Br				Terrance				
Important: If any injury or once.		1 Duriai 2 Cremation 3 D4 Donation 5 Other (Specify 21. Signeture of Funeral Servica Lican 23a. Part 1, Enter the disease, or common 24.	Wygun	01 26	Neme and Add lin L. 1 6401 Ric	lress of Facility Molesworth Ige Road I	n P. A. Damascus	Funeral	Home	,Virginia 0872 Approximate
ysician Medical taminer	-	shock, or heart failure. List only in Immediate Cause (Fine) disease or condition rasulting in deeth)	a. Arteric - St Dua to (or						t	interval Betwaen Onset end Daath
ttending physician and for use as the burial-trensit	an/Medical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last	С	as a consequ						
d by the at	Physic	Part II. Other significant conditions of	ntributing to death but not resul	iting in the un	derlying causa	givan în Part i.			ontributs to	the cause of death?
s been signed by the a 2 should be detached	Completed by						24a. Wa	s an autopsy formed?	con	re autopsy findings liable prior to apiation of cause aath?
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ertific	0	25. Was case referred to medical examiner?	Hamilai.			28. Piace of De	ath (Check only	one)		
Pis di	2	1 Yes 2 No 27. Mennar of Deeth		P/Outpatient	3LI DOA	Other: 4 Nursing H		idanca 6 Ott)
in the	ication	Natural 5 Panding investigation Suicide 6 Could not be	(Month, Day Year)	28b. Tima of injury		☐ Yes 2☐No		how injury occur		Route Number
		4 Homicide determined	building, etc. (Specify)				City or To	own, Stata)		
24 hours a Funeral letely filled	CICA	29a. Certifiar 1□, Certifying Phy (Check only one) 1□, Certifying Phy 2 Medical Exam	aiclsn: To the best of my know iner: On the basis of exemination and manner stated.	iedge, death on end/or inv	occurred at the estigation, in my	time, date end place opinion, death occu	a, end due to the arred et tha tima	ceuse(s) and m , data and piace,	anner as sta and dua to	ited. the causa(s)

State Registrar to H. Esch Gnis. Do 1968 June 25, 1998

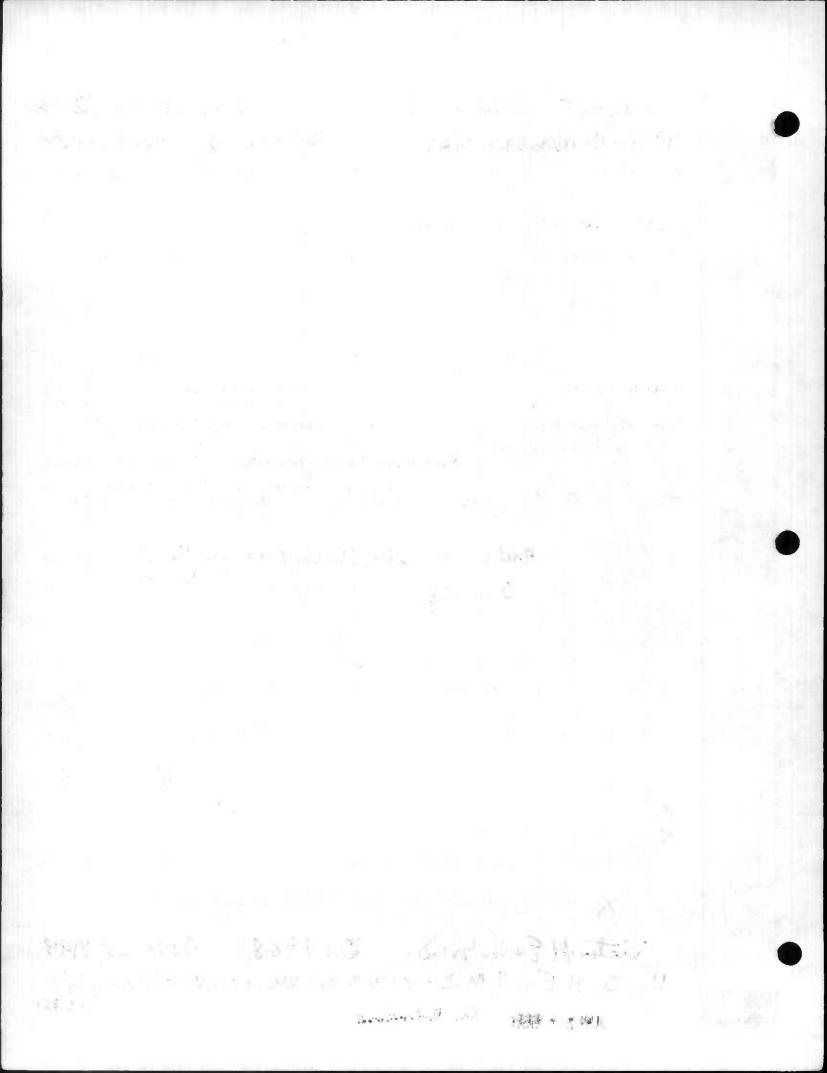
of person who completed causa of daath (Itam 23a) (Type, Print)

on H. Esch, M.D. - 10717-STANMORE DRIVE POTOMAC, M.D.

Day, Yaar)

32. Registrar's Signature

20854



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First Middle Last) **Physician** 6:00PM Graney 1998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner 2308 Delano Lane Forestville Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12/24/25 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F Deys Hours Yrs. Colmar Manor, Md **Director** 579-20-6295 Usual Rasidenca of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Modical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Forestville Maryland 1 Yes 2□No Directo 10e. Street and Number 10f Zin Code 10g. Citizan of What Country? 2308 Delano Lane 20747 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 11 Mentel Status 1 V ves 2 □ No If Yes, Give W Year or Dates: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Mechanic **Automobile** 17. Father'a Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be William M. Graney Lena J. Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Elizabeth Ann Graney/Daughter 522 University Dr. Waldorf, Md. 20602 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition **Burial 2 Cremation 3 Removal from State Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 6/22/98 George P. Kalas Funeral Home eldo 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final Cardiac Arrhythmia disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner Atherosclerotic Heart Disease physician end the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Uncontrolled Diabetes Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequenca of): as US9 signed by the a d be deteched f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy lindings available prior to 24a. Was an autopsy Completed completion of cause of death? page 2 has 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 XNo or Attanding Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Daath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 💢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No 24 hours efter death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, Iamn, street, lactory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1XXCertifying Physician: To tha best of my knowladga, death occurred at the time, date and placa, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the F within 2

completely

31. Date filad (Month, Day, Year) State Registrar

Medical

29a. Cartifiar

(Check only one)

29b. Signeture end title of cartifie

JUN 22 1998

M.K. Mohan, M.D. 6504 Kenilworth Ave. Riverdale, Md. 20737 32 Registrar's Signatura

30. Nama and address of person who completed cayso of death (Item 23a) (Type, Print)

29c. License number

D23125

29d. Date signed (Month, Day, Year)

6/18/98

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** MICHELLE L. Month JULTEN GORDON JUNE 4, 1998 /Medical 4.10 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner P.G. COUNTY HOSPITAL CHEVERLY P.G. COUNTY If Under 1 Year | If Under 24 Hrs 5. Sociel Security Number 8. Dete of Birth 9. Birthplece (State or Foreign PEB. 26, 1976 BROOKLYN N.Y. 7. Age (In yrs. lest birthday) **Funeral** 9. Birthplece (Stete or Foreign 1 M X F Deys 107 62 1307 22 Yrs. **Director** Usuel Residence of Decedent the Manyland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director MD P.G. COUNTY CAPITOL HEIGHTS 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 6816 WILBURN DR. 20743 UNITED STATES Items 23a Funeral death 11 Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. filed within 72 hours efter Hygiene. 1 Never Married 27 Married 1 ☐ Yes 2 ▼ No If Yes, Give Yeer or Detes: Specify: BLACK Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) College (1-4or 5+) than Elementery/Secondary (0-12) DESK CLERK PRIVATE marked other 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Melden Sumame) h end Mentai F. Be Pages 1 and 2 should be PRINCE ALEXANDER JULIEN BARBARA A BURKE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health e : If item 27 is or other tra JAMES A GORDON 6816 WILBURN DR. CAPITOL HEIGHTS MD. 20743 20e. Method of Disposition

Burlel 2 □ Cremetion 3 □ Removel from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other p 20c. Location - City or Town, Stete permit. Pages 1 Department of H Important: If iten any Injury or ott once. MD. VETERANS CEMETERY 6/8/98 CHELTENHAM MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses m1015 22. Name end Address of Fecility ALEXANDER S. POPE FUNERAL HOME 5538 MARLBORO PIKE FORESTVILLE MD. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Intervat Between Onset end Deeth **Physician** Immediete Ceuse (Finel diseese or condition resulting In deeth) /Medical ADVANCE OVARIAN CANCER Examiner Due to (or es e consequence of): Examiner METASTATIC DISEASE OF ABDOMEN The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest pue Due to (or es e consequence of): ettending physicien e for use es the buriel-SUSPECT PULMONARY EMBOLUS P.O. Box 68760, Physician/Medicai Due to (or es e consequence of) signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24e. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? Completed page 2 s certificate 1 Yes 2 No 1 TYes 2 No Attending Physician: director. Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28e. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending s efter deeth. 2 Accident Investigation 1 ☐ Yes 2 ☐ No in by the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide Hospital or To the Hospital within 24 hours e completely filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) and menner es stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) and menner estated.

| Madical Examiner: On the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end menner stated. Medical 29e. Certifier (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Dev. Year) sers ms 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 3301 HOSPITAL DRIVE CHEVERLY PAUL ROGERS M.D. 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State in attender Rordall JUN 22 1999

Registrar **DHMH 16 Rev 6/95**

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2 Date of Deeth Month **Physician** Charles Go odman :02 pin /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yaar) Birthplaca (State or Foraign Country) **Funeral** Days XXM 2□ F Yrs 578-48-2132 Director MAY 29, 1937 WASHINGTON, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limita 10a. State 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No Directo MARYLAND PRINCE GEORGE'S UPPER MARLBORO 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3102 MARCANDO LANE Funeral 20772 filed within 72 hours efter death Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S Armad Forcas? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Datas: 1 ☐ Nevar Married 2 ☐ Married 1 Yes 2 No Specify. Specify: BLACK by 3 Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elementary/Secondary (0-12) College (1-4or 5+) INTELLIGENCE SPECIALIST DEA- FEDERAL GOVT. 4YRS. other 1 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 36 h end Mental I McCOY GOODMAN HAZEL BALINGER 19b. Mailing Address (Streat end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) permit. Peges 1 end 2 sh Department of Health end Important: If item 27 is m any injury or other traum once. 3102 MARCANDO LANE UPPER MARLBORO, MD MICHELLE GOODMAN/ WIFE 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 6-30-98 CHELTENHAM, MARYLAND MD VETERANS CEMETERY 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND RD. SUITLAND, MD 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Non- 8mall cell Lung Cancer, stage TV 8 tucki /Medical Examiner Physician/Medical Examiner attending physician and for use as the buriel-transit that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Due to (or as a consequenca of): Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. the i 3 Probably 4 Unknown signed by 1 Yes 2 No Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen s completion of causa of death? aw certificate hes The 2 1 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After this Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation NA 1 ☐ Yes 2 ☐ No r death. 2 Accident the 24 hours after dest 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 💆 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Data signed (Month, Day, Year) 29c. License number las

Registrar

31. Date filed (Month, Day, Year)

JUN 2 4 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kai - Yin Yenne Ho 8926 Woodyard Ro 8926 Woodyard Road 32 Registrar's Signature

Swite 201 Clinton, hB 20734.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Deeth

BETHESDA MD 20889-5600

should be flied within 72 hours after nd Martal Hygiens. marked other than "natural", or lite Baltimore, Maryland 21215-0020 traumatic event. 6

certificate be executed tran Bud physician er s the buriel-t Box 68760 for use as ed by the e Ö Division of Vital Records, peed certificate has Attending Physician: director, this funeral After filled in by

1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Month Dey MAY 28 1998 **Physician** KRISTIN ELISE HAWK 9:05 AM /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner BETHESDA MONTGOMERY NATIONAL NAVAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 5. Sociei Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** 1□M 2\ F Days 21 Months Hours No Number May 7, 1998 Bethesda, Maryland Director Usuel Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itsms 23a or 28a-f show the Medical Examiner must be notified at the Maryla Virginia Prince William 1 Yes 2 No Director Dale City 10g. Citizen of Whet Country? United States 10e. Street end Number 10f. Zio Code 12920 Kidwell Drive 22193 of America Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Detes: 11 Maritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien. Bieck, White, etc. 1¥ Never Married 2□ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coltege (1-4or 5+) -0-Never Employed None 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) pernit. Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is marked or Jason Keith Hawk Amy Lynn 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) Jason Keith Hawk /Father 12920 Kidwell Drive, Dale City, Virginia 22193 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) June 3 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriei 2 □ Cremetion 3 □ Removel from Stete Rimersburg, Rimersburg Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 1998 Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Fecilit 'n Richard D. Hillis Funeral Home 16248 w 322 North Main Street, Rimersburg, Pennsylvania owandf sens 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final SEPSIS disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner EXTREME PREMATURITY Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical the Due to (or es e consequence of) 60 Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 X No 3 Probably 4 Unknown à 24b. Were eutopsy findings avellable prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? page 2 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicel exeminer? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Netural 5 Pending e Hospital or Attending 124 hours efter death. 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 29e. Certifier Certifying Physician: To the best of my nowledge, death occurred et the time, date end piece, end due to the ceuse(s) end manner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end mediner stelled. To the Vithin 2 29b. Signeture end title 29c. License number 29d. Dete signed (Month, Day, Year) MO D-44634 he end eddress of person who completed cause of deeth (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER MC, USN J.R.GREENWALD, CDR/

Registrar **DHMH 16 Rev 6/95**

State

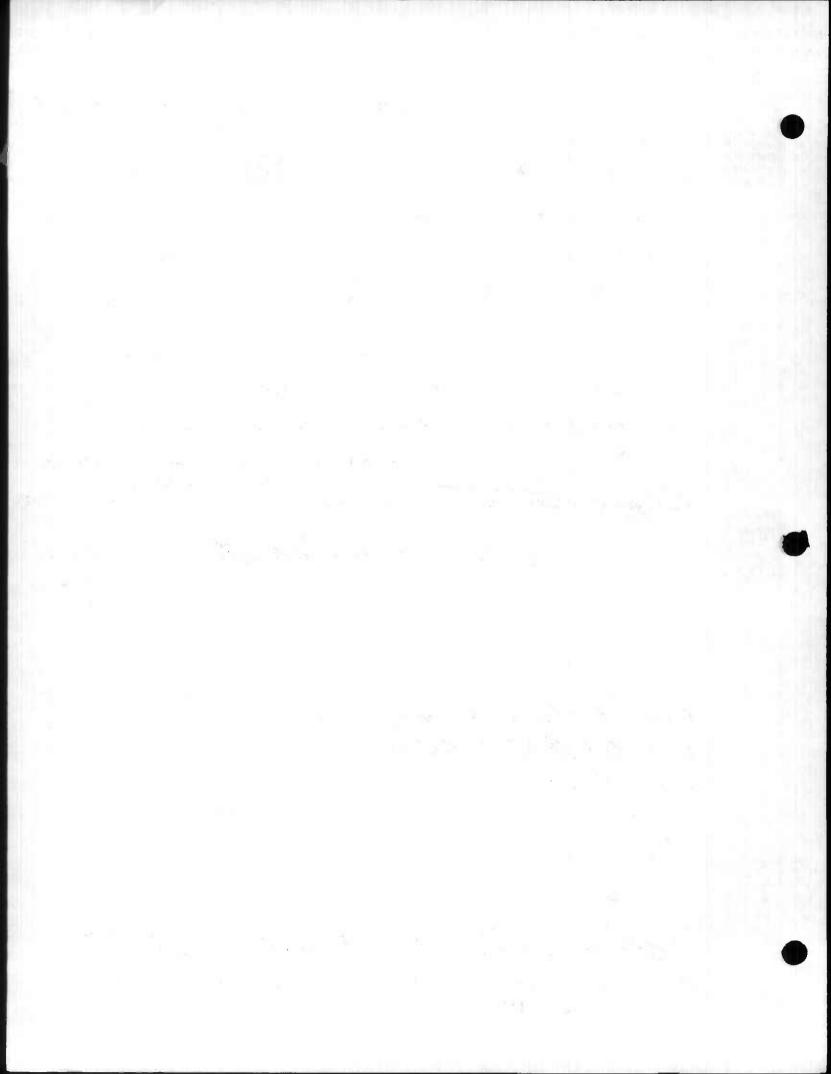
31. Dete fited (Month, Day, Year)

32. Registrer's Signeture

relia Davidson-Randoll

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			State of Ma	•	Certificate of		,	Reg. No. 98	21111
	Physici	an.	1. Decedant's Nama (First, Middla, Last)				2. Dete of Dee	eth Day Ya	3. Time of Death
	/Medic		DIANE		HENERY		June 18	3, 1998	10:3014
	Examir	ner	4a. Fecllity Nema (If not institution, giva straat and number)			4b. City, Town, or Lo	cation of Deeth	4c. County of D	eath
_			6133 Ford Road 5. Social Security Number 6. Sax 7. Aga	/In use land high	day) If Undar 1 Year	Freder:		Freder	ick
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	fand w			10c. City, Town	or Location				10d. Inside City Limits
	Mary First	tor	Maryland Frederick	Fred	erick				1 □ Yas 2 No
	r 28s	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	th wit	al D	6133 Ford Road		2170	02	J	Jnited Sta	ites
	dea	Funeral	11. Marital Status 12. Was Dacedant Ev Armed Forcas?	ver in U,S.	13. Was Decedant of H If Yes, specify Cub	tispenic Origin? (Sp	ecify Yas or No-	14. Race - A	merican Indien, /hita, atc.
21215-0020	d 21215-0020 filed within 72 hours efter death with the Maryland hygiene. thye than "naturel", or Nems 23a or 28a-1 show out, the Medical Examiner must be notified at		1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yas, Giva A 3 ☐ Widowed 4 ☐ Divorced Year or Datas:	>	1 ☐ Yes 2 No	Specify:	riioari, oto.)	Specify:	White
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121	e filed with Il Hygiene. other than		1 2 17. Fathar's Nama (First, Middle, Last)	H	omemaker			own ho	me
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2	d 2 should be ith and Mental Ith and Mental Ith and It	7	HERBERT 19e. Informant's Name/Relationship (Type, Print)		Mailing Address (Street	DORIS	al Pouto Numbo	RAMI	
Ma			IAN P. HENERY / husband		33 Ford Rd				
re,	一丁を書		20a. Method of Disposition	20b. Place of C	Disposition (Neme of crematory or other ple	./ Fledel	Data Mai	20c. Location - City	.702 or Town, Steta
E C	0 0		1 ☐ Burial 2 Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Spacify)		town Cremat		-19-98	Hagareta	wn, Maryland
Baltimore,	그는무를		21. Signetura of Funaral Service Licensea	nagaro	22. Nama and Addre			FUNERAL HO	
m	Depending Depending Permit Per		Bar and Palmed	7	1621 Oposs				Maryland 21702
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	/Medical Examiner		Immadieta Causa (Final disaasa or condition rasulting in death)	My	renders	ma	retu	7	~/ ments
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Records,	v requires been sig should b	edt	1. f. 1/2. Y /	500	1.1		24a. Was	an eutopsy 24	4b. Wara autopsy findings aveileble prior to
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of Vital	G S	To	1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Inpatiant	t 2 ER/Outp	eatient 3 DOA Oth	her: 4 Nursing Ho	ma 5 D Resid	lence 8 Other (5	Specify)
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Division	al or Attendin s aftar death. Il Director: Af ed in by the fu	Certification:	4 Homicide datermined 28a. Place of Injury building, atc.	y - At home, farm (Spacify)	n, straat, factory, offica		City or Tow	street and Number of yn, Stete)	r Rural Routa Number,
	To the Hospital or Attending within 24 hours aftar death. To the Funeral Director: After completely filled in by the fune.	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of examiner: On the best of eand mannar state	exemination and/	death occurred et the til or invastigetion, in my o	me, deta end placa, opinion, death occurr	and dua to tha d ed et the time, d	causa(s) end menne dete end place, end	r es steted. due to tha ceuse(s)
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	-		Plans 9 // see	, ln1	10 11;	0496		6/19	198
			30. Nema and address of person who completed cause of dae	ath (Itam 23a) (T	ype, Print)		.4 -	4////	
			Francis E. Beda	- MP	2001	1. 9th.	STIFE	lerite.	md 2/701
	Sta		31. Data filad (Month, Dey, Yaar) 32. Begistrar	's Signature A	volson Ranhalfy				
	Registr	ar	7011 70 70 100	U					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month Year Lewis Monroe Hurst 23, 1998 June 5:45 AM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Frederick If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 18, 1918 Frederick Memorial Hospital Frederick If Undar 1 Yaar Birthpiace (State or Foreign Country) Virginia 7. Aga (In yrs. last birthday) 79 yrs 5. Social Security Number 6. Sex Days Months DOM 20 F 220-10-5002 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Frederick Frederick Maryland 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 21701 U.S.A. 450 Carrollton Drive 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes, Give 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Painting contractor Painter 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Reatha Grubb Bernard Hurst 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 450 Carrollton Drive, Frederick, MD 21701 Lewis F. Hurst/Son 20c. Location - City or Town, Stata 20b. Piace of Disposition (Name of 20a. Method of Disposition Data Unfon Chapei Cemetery June 26, 1998 Libertytown, MD. 1 Burlai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Keeney and Basford Fuenral Home M00021 106 East Church Street, Frederick, MD 21701 Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death SQUAMOUS CELL Immediate Cause (Finel disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last Due to (or as a consequenca of): Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy 1 ☐ Yas 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending

Physician /Medical **Examiner**

Examiner

Physician/Medical

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Completed

Be

Certification: To

edical

29a. Certifier

(Check only one)

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other treumatic event, the Medical Examinal must be notified at once.

Baltimore, Maryland 21215-0020

physician and the burial-transit 88 attanding p for use as signed by the a peen s certificata has t director, page 2 s director, this After this funeral after death. n 24 hours after death re Funeral Director; A pletaly filled in by the f

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

or Attending Physician:

Hospital

0

within 2 To the the th

25. Was case referred to medical examiner?

1 Yes 2 No

1 Natural investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 📆 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and dua to the cause(s) and manner as stated.

29b. Signature and title of certifian

29c. Licansa number

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

29d. Date signed (Month, Day, Year)

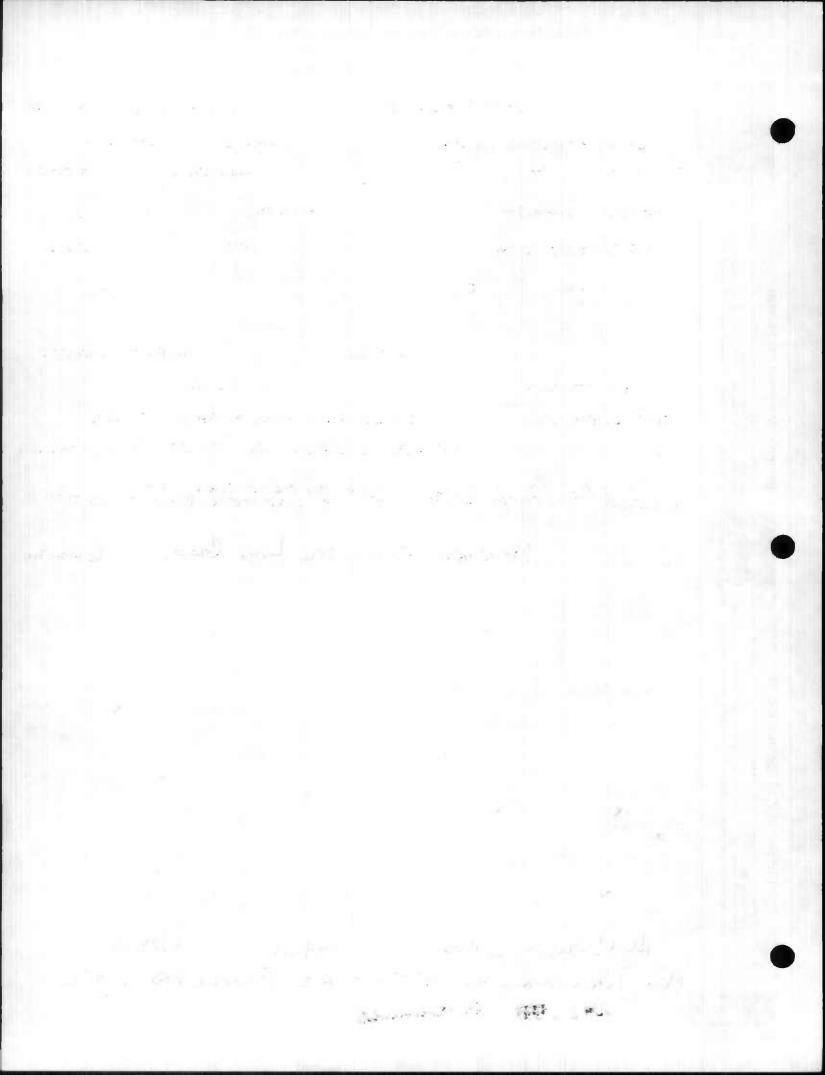
MO ancia 30, Neme and address of person who completed cause of death (Item 23e) (Type, Print)

475 MD

FREDGLICK MD

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Cei	tificate				Reg. No.	20	41	113	
Pi	hysicia	an	Decedent's Neme (First, Middle,							2. Dete of De Month		Ye	er .	3. Time of Deeth	
	/Medic		EILEEN	MARJORIE	HAWK	INS				June	23 23	3, 19	98	2155	
- E	xamin	er	4a. Facility Neme (If not institution,	give street and number)				4b.	City, Town, or L	ocation of Death	h 4c.	County of D	eath		
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	neral ector		218-38-9447	S. Sex 7. Ag	e (In yrs. last	v birthdey) Yrs.	If Under 1 Y Months Da		f Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da Aug • 22	th ly, Year) 2, I	931 M	Birthple Country ary	ce (Stete or Foreig Land	
p ,			Usuel Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	antion						140-	A lester du Atron	
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E S	5 2	Director	10e. Street end Number				10f. Zip Co				_	izen of Whet	Country	y?	
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urs efter de	Tramper n	by Funeral	11. Marital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Detes:			Vas Decedent Yes, specify (□ Yes 2 🔀			pecify Yes or No Rican, etc.)				c.	
d within 72 hours ef	s 1 and 2 should be filed within 72 hours efter death with the Meryland Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23s or 28s-f show other traumatic avant, the Medical Examiner must be notified at		15. Decedent's		1	6a. Deced	lent's Usuel O	ccupetio	n	16b. Kind of Business/Industry			strv		
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d 2 should be file th and Mental Hy	shoul and Mund and mark		19e. informent's Neme/Reletionship	(Type, Pnht)		19b. Meitln	a Address (St	reet end	l Number or Rui	ral Route Numb	er. Cltv o	r Town, Stet	e. Zio C	ode)	
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barmit. Peges 1 er Department of Hea	it. Pege rtment o rtant: If i		20e. Method of Disposition	2448.1002	P.O. Box 352 Huntingtown, MD 20							cation - City	or Tow	n. Stete	
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Sepa	any l		21. Signature of Funerel Service Lk	oensee O o			. Neme and A		. 56	ewell Fu					
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Physi /Med Exam	dical niner	liner	Immediate Cause (Finel disease or condition resulting in death)	· Pos	Due to (or es			nov.	ARY	Em	306	15M			
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5 0	· 6	2	1 Yes 2 No 27. Manner of Deeth	1 L Inpatie		Outpatien	1		4 Nursing Ho	ome 5 Resid			pecify)		
Attending Physician: or death.	the funer	Certification	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not		y Year)	b. Time of Injury		Injury et Work? 1 Yes	3 2 □ No	28d. Describe I	now Injur	y occurred			
tai or Atres selected	ed in by	Certif	4 Homicide determine		ury - At home c. <i>(Specify)</i>	, ferm, stre	et, factory, off	fica		28f. Location (: City or To			Rural F	Route Number,	
To the Hospital or Attending Phywithin 24 hours effer death. To the Funeral Director: After thi	pletely fil	edicai	29e. Certifier (Check only one) 12 CertifyIng I 2 Medical Ex	Physician: To the best of aminar: On the basis of end manner ste	examinetion	dge, deeth end/or Inv	occurred et the estigetion, in r	ne time, my oplni	dete end plece, on, deeth occur	end due to the red at the time,	cause(s) dete and	end menner plece, and o	as stat	ed. ne cause(s)	
To the Youth	com	Σ	29b. Signeture and title of certifier	nolfn	1			cense nu	imber 435			te signed (Me			
5			30. Name and address of person wh	o completed cause of d	eeth (Item 23	a) (Type, I	Print)								
			Mukesh Mathu					rinc	e Frede	erick, N	MD .				
	Stat	e	31. Dete filed (Month, Dey, Year)	32. Registra	ar's Signeture						-				
Re	egistra		JIIN 9 F	1998 Juli	Sand	wor Re	latt!								
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #17, Thomas, 7/1/98, drw Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Robert Darian Harris, Sr. Month 1120 AM **Physician** 22, 1998 June /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** 140 Macrae Ave. Prince Frederick Calvert If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days 1MM 2□ F Yrs. Director 217 18 6529 74 1924 Maryland April 3 Usual Rasidance of Dacedant with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits r than "natural", or items 23a or 28a-1 shot the Wedical Examiner must be notified at Maryland Calvert Prince Frederick 1 ☐ Yas 2 1 No Director 10f. Zip Coda 20678 10e. Street and Number 140 Macrae Ave 10g. Citizen of What Country? United States filed within 72 hours effer deeth Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 1 X Yas 2 □ No If Yas, Giva Yaar or Datas: 1 Never Marriad 2X Married Baltimore, Maryland 21215-0020 Specify: white 1 ☐ Yas 2√€ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Mechanical Maintenance

16b. Kind of Business/Industry
Super Supervisor B G and 15. Decedant's Education (Specify only highest grada completed) Elemantery/Secondary (0-12) Collega (1-4or 5+) Hygiene. 10 utlity is merked other 17 Father's Name (First, Middle, Last) Thomas permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If item 27 is marked other any Injury or other traumatic event sone. 18. Mothar's Name (First, Middle, Meiden Sumame) Thoams Darian Harris Charlotte Mae Shaw 0 19a. Informant's Name/Reietlonship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Loisgene F. Harris- wife 140 Macrae Ave. Prince Frederick, MD 20678 20b. Place of Disposition (Neme of comatary, crematory or other place) June 25 1998Alexandria Virginia 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Funeral Service 21. Signature of Funaral Service Licensea 22. Nama and Addrass of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart fellure. List only one cause on each line. **Physician** CHRONIC OBST. PULM. DISEASE fmmediata Causa (Final disaasa or condition rasulting in daath) /Medical STAGE 5-104rs Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use es the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Undarfying Causa (Disaasa or injury that initieted evants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part t. 23b. Dfd tobacco use contribute to the cause of death? FAILUNE MEANY 1 Yes 2 No 3 Probably 4 Unknown Completed by been si 24b. Ware autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? PHETERY DISEBE certificate has blirector, page 2 s 1 Yas 2 No t □ Yas 2□ No Attending Physician: Be 25. Was casa raferred to medical examinar? 26. Place of Deeth (Check only one) Hospital: Certification: To 1 Yas 2 No Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding invastigation death. 1 ☐ Yas 2 ☐ No 2 Accidant or Attendation of the order 3 Suicida 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida

hours 24 hours To the To the

> State Registrar

edicai

31. Data filed (Month, Day, Year)

29b. Signatura and titla of certifian

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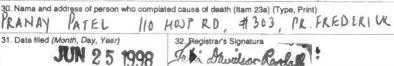
PATEL

29e. Cartiflar

(Check only one)

JUN 25 1998

MD



1 Certifying Physician: To tha bast of my knowledge, deeth occurred at tha time, dete end plece, end due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

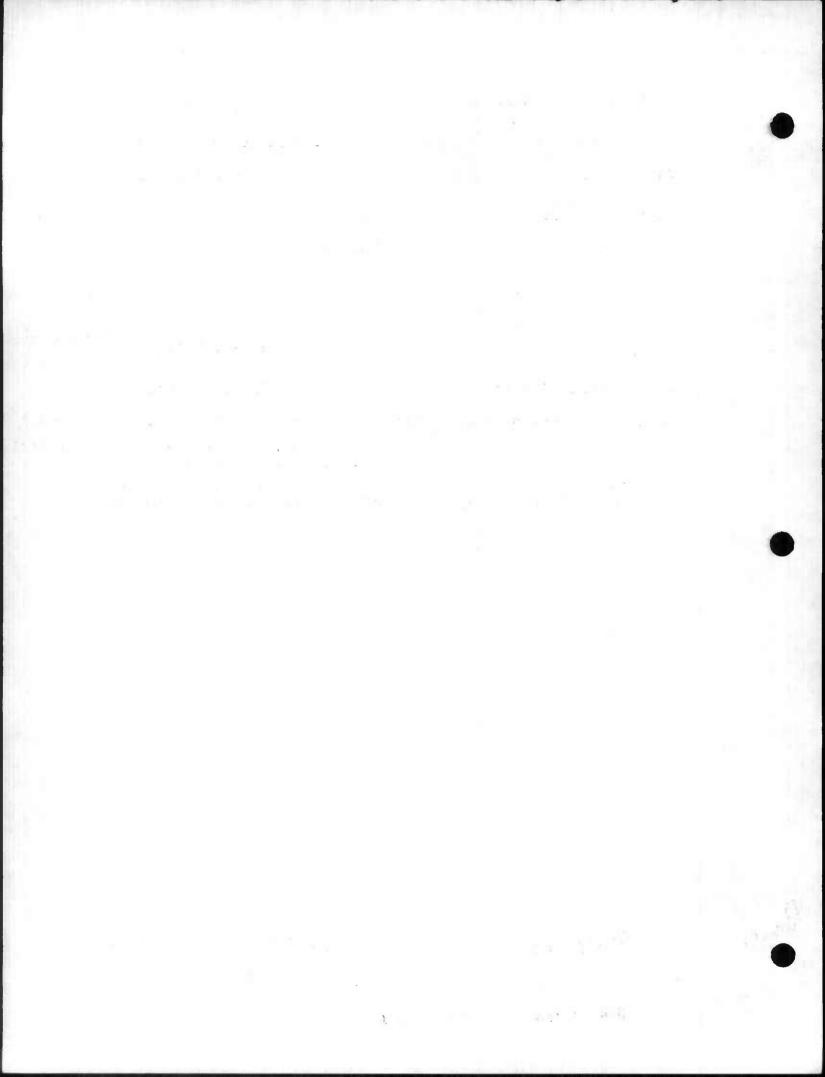
D5014

29d. Data signed (Month, Day, Year)

6/23/98

20178

MD



State of Maryland / Department of Health and Mental	Hygiene
Certificate of Death	Reg. No.

Physician
/Medical
Examiner

Funeral Director

Director

Funeral

à

Completed

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with the Meryland

Item 27 is marked other than "naturel", or items 23a or 28a-f show other treumstic event, the Medical Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a eny injury or other treumatic event, the Medical Examinat mass.

Saltimore, Maryland 21215-0020

Physician /Medical Examiner

death certificate be executed

Box 68760,

Records, P.O.

Division of Vital

Examiner ettending physician and for use es the bunel-transit Physician/Medical signed by þ Completed certificate hes or Attending Physician: effer death. Director: After this certific J_o Certification: filled in by

1 Decedent's Neme (First Middle Lest) 2. Dete of Deeth JUNE MARTHA 98 LOUISE HENRY 7:35 PM 4e. Fecilify Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth COLLEGE VIEW CENTER FREDERICK FREDERICK 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country)
 MD Months Deys Hours 1 □ M 2√2 F 219-01-8389 91 Yrs Usuel Residence of Decedent 10d. Inelde City Limits 10e. State 10b. County 10c. City, Town or Location 1 Yee 2 No MD. FREDERICK FREDERICK LIBERTYTOWN 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 11925 MAIN ST. 21762 U.S.A. 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Yes 2 XNo If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify. Specify: BLACK 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry PRIVATE Elementary/Secondery (0-12) College (1-4or 5+) DOMESTIC FAMILY 7 TH 17. Fethar's Name (First, Middle, Last)
BENJAMIN F. BUTLER 18. Mother's Name (First, Middle, Meiden Sumeme) ASENETH RICE 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) GRACE PATTERSON (DAUGHTER) 11925 MAIN ST. LIBERTYTOWN MD. 21762 20b. Piaca of Disposition (Name of 20c. Location - City or Town, Stete 20e. Mathod of Disposition Date FAIRVIEW CEM. 1 N Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) 11 JUNE 98 Frederick 21. Signeture of Funerel Servica Ligensee 22. Name end Address of Fecility GARY L. ROLLINS FUNERAL HOME 23a. Part1. Enter the disease, or complications het caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Ceuse (Final diseese or condition resulting in deeth) ASCUD 1041) Due to (or es e consequence of):

Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disaese or injury that initiated events resulting in deeth) Lest

Dua to (or es e consequence of):

Due to (or es e consequence of):

Pert II. Other significent conditions contributing to death but not resulting in the underlying causa givan in Pert I.

GOITER

ANEMIA

CV.A.

25. Wes casa referred to medical exeminer?

1 Yes 2 No

27. Menner of Deeth 1 Naturai

2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

2 Medical

28e. Dete of Injury (Month, Dey Year) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Spacify)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury et Work?

1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stele) 1 Certifyles Physician: To the bast of my knowledge, daath occurred at tha tima, data and placa, and dua to tha causa(s) and menner as stated.
2 Medical Examinate On the basis of examinetion end/or Investigation, In my opinion, deeth occurred at tha tima, data and piece, and due to the causa(s) and manner stated.

28d. Describe how injury occurred

24e. Wes en eutopsy performed?

1 Yes 2 10 No

(Check only one) 29b. Signeture end title of certifie

29a. Cartifiar

29d. Data signed (Month, Dey, Year)

23b. Did tobacco use contribute to the cause of death?

1 Yee 2 No 3 Probably 4 Unknown

24b. Wara eutopsy findings eveileble prior to completion of causa of death?

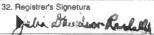
1 Yes 2 No

30. Name end eddrass of person who complated causa of daath (Itam 23a) (Type, Print)

EUGENE CASAGRANDE, M.D. 1564 OPOSSUMTOWN PIKE FRED. MD. 21702 31. Date filad (Month, Dey, Year)

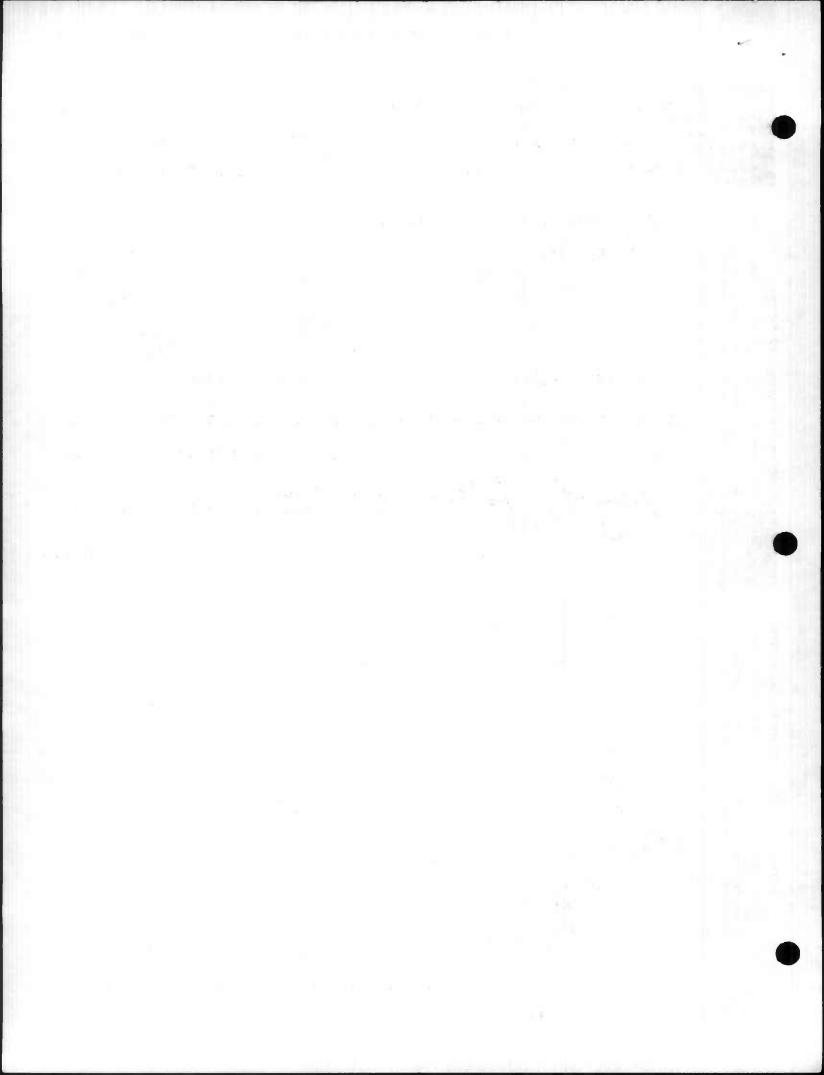
State Registrar

JUN 0 9 1998



24 hours e Funeral C

within 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE 12:41 PM Hanback Richard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Prince Georges Doctors Community Hospital Lanham 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 8. Date of Birth May 30 Yel 929 9. Birthplaca (Stata or Foreign Washin), D.C. 7. Age (In yrs. last birthday) 1√2 M 2□ F Months Days 577-34-8585 69 Yrs. Usual Residence of Decedent 10a State 10d. Inside City Limits 10h County 10c. City, Town or Location 1 X Yes 2 □ No Director Brentwood Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4313 39th. Pl. 20727 U.S.A. Funerai 11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - Amarican Indian, Black, White, etc. 1XX es 2 No If Yes, Give Yaer or Detes:951-1953 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: by 3√ Widowad 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Dacedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Air-Conditionig Mechanic Adams Heating & Condtion 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry S. Hanback 19a. Informant's Name/Ralationship (Type, Print) Golden V. Langley 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Richard J. Hanback (Son) 4313 39th. Pl. Brentwood, Maryland 20727 20b. Place of Disposition (Name of cemetery, crematory or othar place) 20a. Method of Disposition 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removal from State Md. Veterans Cemetery 6/29/98 Cheltenham, Maryland 5 Other (Specify) 4 Donation 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 n. Enter the disaase, or complications that caused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Immediate Causa (Final diseasa or condition resulting in daath) MINS Interaction Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) MINS Physician/Medical ue to (or es a consaquence of Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to complation of ceuse of daath? Completed 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examinar? Be 26. Place of Death (Check only one) Hospital: 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To ER/Dutpatient 3 DOA 1 ☐ Inpetient 2 ☑ 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide

/Medical Examiner ettending physician and for use as the buriel-transit Box 68760, P.0. Division of Vital Records, Deed Sec page 2 certificate this funerel s after death. ai Director: After th or Attanding filled In 24 hours a Hospital Medicai **Stely**

Funeral

Director

28a-f show

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items 23a

other traumatic event, the Medical Examiner must be notified at

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, in a Medical Exams

Physician

2 should be li

RICHARD HANBACK

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

LANHAM

29a. Certifier (Check only one)

4 - Homicide

If Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

DUUNITY HOSPITAL

29b. Signature 30. Name

29c. License number

29d. Date signed (Month, Dav. Year)

State Registrar

31. Date filed (Month, Day, Year) 32. Begistrar's Signature

DHMH 16 Rev 6/95

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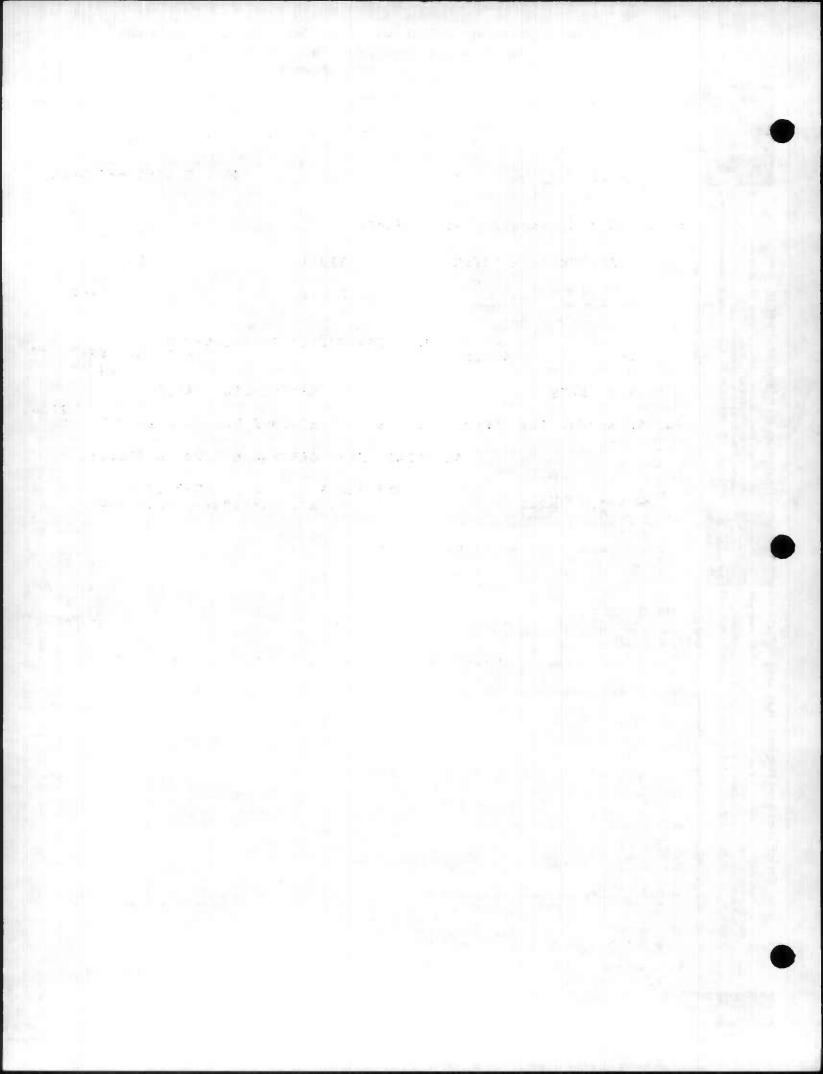
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Ma	d2s th an 7 is r		Sylvia Carter/I		5.3.1 W	ilson	and Number or Run Bridge	Dr #	A2.Oxc	on Hil	20745
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Baltimore,	Pages 1 and 2 mant of Health a ant: If item 27 is ury or other train		1 ☐ Burial 2 ☐ Framation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lamoval trom Stete Ba	ematory	6/25/9	g Laur	rel, Mo	1.		
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	To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Aft completely filled in by the fur	edical	29a. Certifier 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying Physical Examination 1 ☐ Certifying	eician: To the best of my kno ner: On the bests of axamine and mannar stated.	owledge, death occ stion and/or investi	curred et the tir gation, in my o	me, dete end plece, pinlon, death occurr	end due to the ed at the time,	ceusa(s) end ma dete and piece, a	inner as state and due to the	d. s ceuse(s)
	ompl	Me	29b. Signature and title of cedifier	230300		29c. Licans	a number		29d. Dete signed (Month, Dey, Year)		
			bha la A						D31124 G [25] MASH., D. C. 2003. RIUGW PENNSYLVANIA AUE. N.		
	(A)		30. Name and addrass of person who co	empleted causa of death (Ital	m 23a) (Type. Prin	t)	WAS	H. D. C	. 200	37	
					1.7. 2	100W	PEMMSY	LVANIA	Adé. D	N.W	
	Sta	te	31. Deta tiled (Month, Day, Year)	ESURIERO M 32 Ragistrario Signi	atura P A 4						
	Registr	ar	JUN 2 3 1996	3 State of Downer	arrantal						

THE COMP

State of Maryland / Department of Health and Mental Hygiene

	Decedent's Nama (First, Middla, Last		Certifica	te of Death	2. Date of Dec	Reg. No. 9	3. Time of Death
Physician		JONES			JUNE JUNE	Day 199	ar 4 910
Medical xaminer	4a Facility Name (If not Institution, give	street and number)	ZENTER		r Location of Daath		
	1	0/11/1		er 1 Yaar If Under 24 Hi	MORE		NE
eral ctor	5. Social Security Number 6. Sa 1D 1D 1D 1D 1D 1D 1D 1D 1D 1D 1D 1D 1D	7. Aga (In yrs.	Yrs. Month		n. (Month, Da	y, Year) 3 1944 M	Birthplaca (State or Foreign Country) ARYLAND
rector	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Insida City Limits
Director	MARYLAND ANNE A	RUNDEL GLE	N BURNIE	In Code		10g. Citizen of Whet	1 Yas 2 No
		DOE DRIVE	101. 2				Ostality
Funeral	208 B. SOUTHBRI 11. Marital Status	12. Was Decedent Ever in U Armed Forces?	,S. 13. Was Dec	21061 edent of Hispanic Orlgin? ecify Cuban, Mexican, Puc	(Specity Yes or No-	US - 14. Race - A	American Indian, Vhite, etc.
ò	1 □ Navar Married 2 □ Married 3 □ Widowed 4 【X) Xivorced	1 ☐ Yes 2 No If Yes, Give Year or Datas:		24 No Specify:	nto moan, ato.)	Specify:	BLACK
leted	15. Decedent's Edu (Specify only highast grad	cation a <i>completed)</i>	16a. Decedent's Us (Give kind of v	ual Occupation york done during most of w use retired) FOSTER GR	rorking	16b. Kind of Busine	ess/Industry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4 yrs.	DIRECTOR	"FOSTER GR		NTS A.A. CO.	DEPT. OF
Bec	17. Fether's Name (First, Middle, Last)	1 7 2 0 .		18. Mother's N	ame (First, Middle,	Maiden Sumeme)	AGING
To	CALVIN JONES			MENTHE		AMES	
	19a. Informant's Name/Relationship (7) EDWARD BROWN, I			ss (Street and Number or SOUTHBRIDG			21001
	20a. Method of Disposition	20b. F	Place of Disposition (No	eme of	Dete	20c. Location - City	
	1X Burial 2 ☐ Cramation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			EM. GARDEN	\$ 6/9/9	8 ANNAPO	LIS, MD.
	21. Signatura of Funeral Service Licens	90		and Address of Facility EESE & SON	S MORTII	ARV P A	
	Jarry S. Kas	40	821 W	EST ST. AN	NAPOLIS	. MD. 21	401
п	23a. Part1. Enter the disease, or compi shock, or heart feilure. List only o					rrest,	Approximate Intervel Between Onsat and Death
1	Immediate Cause (Final	CEVERE	CARDI	OMYOPAT	THY		20 YEARS
	disease or condition resulting in death)	9	or as e consequence o				20 121113
Examiner),	TENSI				10 YEARS
Exar	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury		or as a consequenca o	FAILUR	F.		3 MONTHS
edicai	regulting in death) I set		r as a consequenca of):			
	leasting in death) Last	HUMAN IN	nmuNODE	FICIENCY	UIRUS 1	NFECTION	N3 YEARS
clan							bute to the cause of death?
by Physiclan/M	Part II. Other significant conditions con	tributing to death but not les	ulting in the underlying	cause given in Part I.			Probably 4 Unknown
Completed by Physic						an autopsy 2-	4b. Were autopsy findings available prior to completion of cause of death?
To Be Comp					10	Yes 212 No	1 Yas 2 No
BeC	25. Was casa referred to medical examinar?			26. Place of C	leath (Check only o	one)	
2	1 ☐ Yes 2 ☑ No	T	ER/Outpatient 3 :			dence 6 Other (Specify)
cation:	27. Manner of Death 1 Neturei 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe	how Injury occurred	
edical Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Specif	ome, farm, street, fect y)	ory, office	28f. Location (City or To	Street and Number o wn, State)	or Rural Route Number,
completely filled in by the fig.	29e. Certifier (Check only one) 1 ☐ Certifying Physical Exami	sician: To the best of my knower: On the basis of examine and manner stated.	wiedge, death occurre tion end/or investigation	d at the time, date and pia on, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manne date and place, end	or as stated. due to the cause(s)
2	29b. Signature and title of certifiar	DECIDENI	7	9c. License number	20	29d. Date signed (M	fonth, Day, Year)
	> L187 Homas,			As 244 16 11			
	30. Name and address of person who con LIZY THOMAS.	mpleted cause of death (item HARBOR	n 23a) (Type, Print) HOSPITA	L CENTE	R, BAL	TIMORE	, MD
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa					



State of Maryland / Department of Health and Mental Hygiene 98 2 1 1 1 9

							Cer	tificate of	f Death		Reg. No.) 6		9
			1. Decedent's Name (Fi		st)					2. Date of De	eth	Vere	3. Time of I	Death
	Physici /Medi		Virginio	(]	ones.					Month	Day S	98	6:20	pm
	Exami		4a. Fecility Name (If not	institution, giv	e street and number	er)			4b. City, Town, or	Location of Deatl	h 4c. County	of Death		
			Mariner Nu	irsing	Care Cent	ter			Laurel		Princ	e Geo	rges	
1	Funerai		5. Social Security Numb	er 6. S	ex 7.	Age (In yrs. la:	st birthday)	If Under 1 Yea Months Days					lace (State or	r Foreign
	Director		579-34-3427	7 1	□M 2\\ F	83	Yrs.	WOTERS Day:	S Hours Will	July 24	, 1914	Carbo	ndale,	WVA.
	р ,	1	Usual Residence of Dec				_							
	shyla	Ļ		o. County		10c. City,	Town or Loc	cation				11	0d. Inside City	
	Ba-f	cto	D.C.			Wash	ingto	n					1X) Yes	2 ∐ No
	ith th	洁	10e. Street end Number					10f. Zip Code			10g. Citizen of	Whet Coun	itry?	
	23.	ie i	627 Jeffers	son St.	NW			20	0011		USA			
	ours after death with the Maryian el', or items 23e or 28e-f show Examiner must be notified at	Funeral Director	11. Marital Status		12. Was Decade Armed Force		. 13. W	Vas Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No	- 14. Rac	ce - Americ		
20	or li	Y.	1 Never Married		1 Tes 2	Ñ No		☐ Yes 2X No		, , , , , , , , , , , , , , , , , , , ,	Specif		oto.	
00	irel',	d by	33⊠Widowed 4 □	Divorced	Year or Date	s:					Specif	Bla	ck	
21215-0020	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "naturel", or items 23e or 28e-f show event, the Medical Exertine must be notified at	Completed	15. (Specify o	Decedent's Ed nly highest gre	ducation de com <i>pleted)</i>		(Give I	ent's Usual Occi	e during most of wa	rking	16b. Kind of B	usiness/Ind	dustry	
12	ne.	d m	Elementary/Secondar	y (0-12)	College (1-4d	or 5+)		O NOT use retir	_			- 1		
	be filed vital Hygie d other t		10th 17. Father's Name (First	A A A distribution A contract			Teac	hers Aid	7		Privat		001	
Maryland	2 should be filed within end Mental Hygiene. Is marked other than surmatic event, the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental than the Mental t	Be								me (First, Middle,		10)		
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Mai	l 2 st le n le n raun		19a. Informent's Name/				19b. Mallin	g Address (Stree	et and Number or R			State, Zip	Code)	
	s 1 and 2 should f Health end Mer fem 27 is marks other traumatic		Margaret M		er/Daughi				Rd. #201	Laurel,		0708		
0	t of H		20a. Method of Dispositi 1 □XBurial 2 □ Cr		Removal from Sta	0.00	ce of Dispos n <i>etery</i> , c <i>re</i> m	sition (Neme of atory or other pi	ace)	Date	20c. Locetion	City or To	wn, State	
E	men men ant:		4 Donation 5 D					Memorial	L Park	6-22-98	Landov	er, M	D.	
Baltimore,	permit. Peges 1 and Depertment of Health Important: if item 27 eny injury or other tr once.		21. Signature of Funera	I Servica Lican	see		22. M:	Name end Add	ress of Facility S Funera	1 Home	Inc			
ш	20599		1. P.	Mars	hell	/		217 9th		Washing		200	1.1	
			23a. Par 1. Enter the di shock, or heart fail	sease, or comp	plications that caus	ed the death.	Do not ente	or the mode of dy	ing, such es cardia	c or respiretory e	rrest,	. 200	Approximate Interval Betw)
а	Physician			and and only				1				1	Onset and D	
4	/Medical		Immediate Ceuse (Final disease or condition	I	K	ecusz	nont-	Ash	nation	TUPLI	mmia	2	2 4	19000
	Examiner	I. I	resulting in deeth)		8	Due to (or a	as a consequ	uence of):	1000	prica	marec	-		46
	D 45	ine		_				1						
	requires that the death certificate be executed seen signed by the attending physician end thould be detached for use as the bunal-trensit	Examiner	Sequentially list condition	ons,	D. — — — —	Due to (or e	s e consequ	uenca of):						
00	e ex		Sequentially list condition if any, leading to immed cause. Enter Underlying Couse (Disease or Injury that Initiated events	g								1		
68760,	ate b hysic the b	Medical	thet Initiated events resulting in death) Last		G,	Due to (or a	s a consequ	ienca of):				-		
9 x	certifica ding ph	M e	,,	L										
Bo	eath cer attendin I for use	an			d							1		
	he at	Physician	Part II. Other algnificant	t conditions co	ontributing to death	but not result	ing In the un	derlying cause g	given in Pert I.	23b. Dld	tobacco uae co	ntribute to	the cause of	f death?
P.0	es thet the de igned by the a be detached f	Ph	Caroli	o c	Ax	11/1	0.11	à		10	Yes 2 No	3 Prob	pably 400	Únknown
	es the	þ	Colon	uc		ry in	we	ses.	-					
Records,	v raquire baen si should I	Completed	A. Ca.	. C	- Chade	Ca	. D.J	Vasual	2		an autopsy ermed?	24b. We	ere autopsy fir ailable prior to	ndings
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Vital	certificete rector, pag	Be C	25. Was cese referred to	o medical					26. Place of De	ath (Check only o				
f V	S 8 8	ToE	exeminer?		Hospital:	itient 2 E	R/Outpatient	3□ DOA O	there.	lome 5 ☐ Resid		er (Specifi	()	
Jou	g Physer this		27. Manner of Deeth		28a. Dete of Ir (Month, I		8b. Time of	28c. Inj			how Injury occur		,	
0	Attending Is death.	atio	1 Matural 5 [2 ☐ Accident	 Pending investigation 		Joy 1 601)	Injury		Yes 2 No					
Division	s after death.	tfic	3 ☐ Suicide 6 [4 ☐ Homicide	 Could not be determined 	28e. Place of	Injury - At hom etc. (Specify)	e, farm, stre	et, factory, office	9	28f. Location (S City or Tox	Street and Numl	er or Rura	Route Numb) <i>ΘΓ</i> ,
	s after or all Dir	Certification:			building,	etc. (Specify)				Ony or Tov	wii, State)			
	To the Hospital or / within 24 hours after To the Funeral Direct Completely filled in b		29a. Certifier 112	CertifyIng Phy	ysician: To the bes	st of my knowle	edge, death	occurred et the t	time, date end plece	e, end due to the	cause(s) end ma	anner as st	ated.	
	he H in 24 he Fi plete	edicai	one)	Medical Exam	and manner	of examination stated.	n and/or inve	estigation, in my	opinion, death occu	irred et the time,	date and plece,	and due to	the cause(s)	
	To the within 2 To the comple	Σ	29b. Signature and title of	of certifier	A ^		4	29c. Licer	nse number		29d. Date signe	d (Month, I	Day, Year)	
				1		N	1-1	0	2472		6/19	119	8	
1	(3)		30. Neme and address of	f person who	completed cause of	f death (Item 2	3e) (Type, P	Print)	, 0,	•	1	-	,	
(SYEX S	ADIG	1, 143	33 1	Aure	En Ba	WIE KY	1,5+2	108 LA	UKEL	MD2	0708
	Sta	te	31. Date filed (Month, Da	ay, Year)	32. Regis	strar's Signatur	е			,				
	Registr	ar	JUN	ZZ 199	8 AK	Minds	- Karlas	(

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Amended # 5. Per F.H. PGC 6-23-98 Certificate of Death Reg. No. 2. Dete of Death 3. Time of Deeth 1 Decedent's Nama (First Middle Last) Day Month MARION JORDAN JUNE 16,1998 2:42pm 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth MARINER HEALTH OF SOUTHERN MARYLAND CLINTON PRINCE GEORGES If Undar 1 Year | If Undar 24 Hrs. Birthplace (Steta or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) 1□ M 210 F Months Days Hours Yrs 24-5811 82 JULY 12,1915 Virginia Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yas 2 No Maryland Prince Georges SEAT Pleasant 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 406 71st Avenue 20743 United States 14. Rece - American Indien, Black, White, atc. 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 11. Meritel Stetus 1 Yes 2 No If Yes, Give Yaer or Datas: 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) Teacher Aide/Practical Nurse | Education/Medical 18. Mother's Nema (First, Middle, Maiden Sumeme) 17. Fathar's Neme (First, Middle, Last) George Washington Artie G. Douglas 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Mignon Kirby / Daughter 6801 Bock Road #328, Ft. Washington, Md 20744 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 6/20/98 Harmony Memorial Park Landover, Maryland 22. Name and Address of Fecility 21. Signature of Funaral Service Licensee ALEXANDER S. POPE FUNERAL HOMES M859 5538 Marlboro Pike, Forestville, Md. 20747 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete interval Batween Onset and Deeth 10 days. Immediate Cause (Final disasse or condition resulting in deeth) SEPSIS Due to (or es e consequence of): 10 days ENTEROCOCCI Sequentially list conditions, if eny, leading to Immadiate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): 10 days URINE INFECTION Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to competion of causa 24a. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

15

Physician

/Medical

Examiner

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Completed

Funeral

Director

must be n

then "natural", or llams the Medical Examiner m

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Baltimore, Maryland 21215-0020

should be and Mental

permit. Pages 1 and 2 st Department of Health and Important. If New 27 is n any injury or other traus

1 1

Physician/Medical Examiner physician and tha burial-transit for usa as t þ should I Completed

Be

2

Certification:

edicai

4 Homicide

tha death certificate be axecuted The law requires that has a 2 cartificata ha Physician: After this or Attending death. To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

26. Plece of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

25. Wes case referred to medicel axaminer? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28b. Time of

28c. Injury et Work? 1 Yes 2 No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29c. License number

29b. Signeture end title of certifier Hancho

IUN 22 1998

D 50653

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

SURRATTS ROAD. CLINTON M.D. SURAWA 7501 GYAN CHAND

31. Dete filed (Month, Dey, Year)

32 Registrar's Signeture

State Registrar

Anist in the straight

mended # 8	State of Maryland / Department of Health and Per F.H. PGC 62598 cr Certificate of Death	Reg. N	40. 98 2 2 2							
Physician /Medical Examiner	1. Decedent's Neme (First, Middle, Lest) Edward Charles Jagers Jr. 4e Fecility Neme (If not institution, give street end number) Doctor's Hospital Lanham	May 21 or Location of Deeth	Yeer 1998 2:49p.m.							
Funeral Director	5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24	Hrs. 8. Date of Birth (Month, Dey, Yes	MD							
h the Maryland r 28a-f show incritied at	Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location MD P.G. Adelphi	Sept.12,8	10d. Inside City Limit							
uth with the Mar 23a or 28a-f el unt be notethed rai Director	10e. Street and Number 2711 Rambler Pl. 10f. Zip Code 20783	10g. (Citizen of Whet Country?							
d within 72 hours efter death values. 23 within 72 hours efter death variable. The Medical Exam for must completed by Funeral	11. Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Status 1 Named Forces? 1 Named For	? (Specify Yes or No- uerto Rican, etc.)	14. Rece - American Indian, Bieck, White, etc. Specify: Black							
filed within 72 hours efter death with the Maryland Hygiene. Hygiene. ent, the Medical Examinet must be norified at a Completed by Funeral Director	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Student	tudent p. done during most of working fee. DO NOT use retired)								
d 2 should be filled th and Mental Hygi 7 is marked other traumatic event, To Be Cc	17. Fether's Neme (First, Middle, Last) Edward Charles Jagers Sr. 18. Mother's Car	18. Mother's Neme (First, Middle, Malden Sumam Les Jagers Sr. Carolyn Shacklefo								
Pages 1 and 2 st ant of Health end it: If New 27 Is n ry or other traun	19a. Informent's Neme/Reletionship (Type, Print) Carolyn Jagers 2711 Rambler P1 Adelphi, Md. 207 20e. Method of Disposition 18 Buriei 2 Cremetion 3 Removal from Stete 4 Donetion 5 Other (Specify) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, 2711 Rambler P1 Adelphi, Md. 207 20c. Location - City or cemetery, cremetory or other piece) Ft. Lincoln Cemetery, 5/27/98 Brentwood									
permit. Pages 1 and Department of Healt Important: If item 2 any injury or other other.	22. Name end Address of Fecility Hodges and Edward 3910 Silver Hill RD. Suitland, Md 24a Part Enter the deepen of completely shifted caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, and completely one date on one each line.									
Physician /Medical Examiner	Immediete Ceuse (Finel disease or condition resulting in death) e. Cardiac Arrest Due to (or es e consequence of):		Intervel Between Onset end Death							
The law requires that the death certificate be executed at has been signed by the attending physician end pege 2 should be detached for usa as the bunial-transit completed by Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest b. Cardiac Congenital Anomal Due to (or es e consequence of): c. Due to (or es e consequence of): d.	ies	years							
as that the death certificat igned by the attending phy be detached for usa as th by Physician/Medi	Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did tobac	co use contribute to the cause of dear							
The law requiras the sata has been signed page 2 should be d		24e. Wes en eu performed	utopsy 24b. Were autopsy finding							
certificata has rector, pege 2	25. Was cese referred to medical 26. Plece of	1 ☐ Yes	2 📆 No 1 ☐ Yes 2 ☐ No							
ng Phys fter this uneral di on: To	27. Menner of Deeth 1 Neturei 5 Pending (Month, Dey Year) 2 Accident investigation 3 Sulicide 6 Could not be									
To the Hospital or Attendia within 24 hours after deeth. To the Funeral Director: A complately filled in by the for Medical Certificati	4 ☐ Homicide building, etc. (Specify) 29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death	City or Town, St	e(s) and manner as stated.							
To the within 2 To the compla	29b. Signeture and fittle of certifier 29c. License number	29d.	Date signed (Month, Day, Year)							
6	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) James E 2011 ock 8/18 Good Luck Pd L	ANHAM M	8 20706							
State Registrar	31. Dete filed (Month, Dey, Year) JUN 2 3 1998 32. Registrer's Signeture									

was in the way of the wife

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month LEWIS L. JOHNSON JUNE /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HYATTSVILLE HEARTLAND OF HYATTSVILLE If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. Date of Birth (Month, Day, York) 8. 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Citizen of What Country? 1700 - 24TH STREET, N. E. 20002 U. S. A. Funeral 12. Wes Decedent Ever in 11 S. Armed Forces? 2 - 15 - 44 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) If Yes, Sieve Yeer or Detes: 4 - 9 - 46 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: BLACK þ 3 Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filed within 7 Department of Haalth and Mental Hygiene. Important: If Item 27 is marked other than "n any Injury or other traumatic event. In the Mental Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the C Elementery/Secondary (0-12) 12TH GRADE College (1-4or 5+) SUPPLY CLERK US DEFENSE DEPT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **JOHNSON** LUCAS H. **CECILIA** MOORE 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LILLIAN J. ELLIOTT - SISTER 2130 SOUTH OAKLAND ST. ARLINGTON, VA 22204 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Commation 3 Removal from State FT. LINCOLN CEMETERY 6/25/98 BRENTWOOD, MD 4 Donation PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N. E. WASH., D. C. 20002 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLERATIC CARDIOVASULAR DISEASE Examiner Due to (or as a consequence of) physician and the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events reaulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23h. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown RENAL FAILURE 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed HEPHROTIC SYNTROME ATRIAL FIBRILLATION 1□Yes 2NNo The the Hospital or Attending Physician:
within 24 hours after death.
To the Funeral Director: After this cartifical completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ♠ No Be 28. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at / Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier Medical 29b. Signature and title of certified 29c. License numbar 29d. Date signed (Month, Day, Year) andm 16489

4203 QUEENS BURY Rd, HYATTSVILLE WD 20781

State Registrar

J. HAND

31. Date filed (Month, Day, Year)

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

MA

32. Registrar's Signature

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J.	Physicia /Medic		Sharon				Jon			JUN	21	q'&	1750
	Examin	er	4a Facility Name (If not institution, gir	1	"cialt	u H	rit	-	8	ocation of Deatl		ty of Death	
			Lorien Medic 5. Sociel Security Number 6.			hast birthday	1 1000000000000000000000000000000000000					Wan	
ı	Funeral Director		577-80-8289	1□M XXXF		40 Yrs.	Months Day		Min.	January	15, 1958	Wash	place (State or Foreign
Н	•		Usual Residence of Decedent										
	show		10a. State 10b. County		10c. Cit	ty, Town or L							10d. Inside City Limits 10X Yes 2 □ No
	the Merylar 28a-f show	ecto	D.C.				1	ashingt	on				
	ath with the Meryla 23a or 28a-1 show	급	10e. Street and Number 4420 Edson Place.	NE			10f. Zip Code	2	0019		10g. Citizen o		ntry?
	within 72 hours after death with the Meryland ene. than "natural", or items 23s or 28s-f show he Medical Examinet must be nouted as	Funeral Director	11, Maritel Status	12. Was Deceder	nt Ever in U	.S. 13.	Wes Decedent of			ecify Yes or No		ece - Ameri	ican Indian,
0	al', or Herre Examiner m	Fun	Armed Forces? 1 Navieur Married 2 Married 1 Yes 2 M If Yes, Give							Rican, etc.)		ack, White	, etc. ack
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15-6	72 h	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)		16e. Dece	dent's Usual Occ kind of work don DO NOT use reti	upation e <i>during m</i> os	st of work	ing	16b. Kind of	Business/Ir	ndustry
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	should be filed within 72 hours aft of Mentel Hygiene. marked other than "natural", or matic event, the Medical Exemi	Be Co	17. Father's Name (First, Middle, Last	1)				-	er's Nem	e (First, Middle	, Maiden Sum	ame)	
/lar	2 should be end Mentel is marked o	ToB	Eddie Gord	dson						Bettie C	Jones		
Maryland	permit. Pages 1 end 2 should be filed Deperment of Health and Mentel Hyg Important: If Item 27 is marked other any Injury or other traumatic event, ones.		19a. Informant's Name/Relationship				ing Address (Stre Park Road,						
-	l end lealth m 27		Ms. Bettie Savage (Mc	ouner)	20h F		osition (Name of	n.w. Ap	υ. π4	Date	20c. Location		
Jor	nt of h		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐			cametery, cre	matory or other p		nc !	6/25/98	Clinton,	111	
Baltimore,	permit. Pages 1 end Depertment of Health Important: If item 27 any Injury or other ti once.		4 Donetion 5 Other (Special Service Lice		1 01				1		CT Incom,	, mai y i	ara
Ba	permit. Dependent		1 4	7 /.	1/2.		2. Name and Add			, Inc. . Washir	naton D	C 20	019
			23a Sent Enter the disease, or con nock, or heart failure. List only	nplications that caus	ed the deat	th. Do not an						. 20	Approximete Interval Between
	Physician		priock, or heart failure. List only		_							1	Onset end Deeth
	/Medical Examiner		Immediate Cause (Final disease or condition		set	sis							10 Days
	LAUGHINE	Examiner	resulting in death)		Due to (d	or as a conse	quenca of);	1	111	101			6 months
	neit insit		-	b. 0	Q (Ya		eculsi	+45	0 (Cer			6 monds
oʻ	be executional cities and purial-transformations.	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Pa	Partial ayadryblegia								1 Year
3760,	e y	cal	Cause (Disease or injury that initiated events	c		or as a conse		1	(J. C			
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P.0.	the de	ysic	Part II. Other significant conditions			-	underlying cause	given in Pert	l.		~		to the cause of death?
	that ned by dete	y Pt	Kespirato.	ry ra	ilu-	re				10	Yes 2 No	3 □ Pro	obably 4 ☐ Unknown
Records,	v requires been sign should be	ed b	Respirato	7						24a. Wes	en eutopsy ormed?	24b. V	Vere autopsy findings vallebie prior to
eco	2 S	Completed	MIEMIO							poin	omiou i	C	ompletion of cause f death?
- B	The law ate has to page 2 s	Com								10	Yes 2 No	1	☐ Yes 2√XNo
/ita	ysicism: The law is certificate has t director, page 2 s	Be	25. Was case referred to medical examiner?	11					e of Deal	th (Check only	one)		
of Vital	this el o	10 To	1 ☐ Yes 2 No 27. Manner of Deeth	Hospital:		ER/Outpatie	I AOU III		ursing Ho	ome 5 Res	idenca 6 Co		ify)
on	ding After fune	tion	1 Neturel 5 Pending 2 Accident Investigation	28a. Date of Ir (Month, L	Day Year)	28b. Time o Injury	V	ork? □ Yes 2□	No	200. Describe	now injury occ	uned	
Division	Attending Physicism: or death. setor: After this certific by the funeral director.	ffica	3 ☐ Suicide 6 ☐ Couid not t	28e. Pleca of	Injury - At h	ome, farm, s	treet, factory, offic			28f. Location	(Street and Nu	mber or Ru	ral Route Number,
Ö	s effe	Certification:	4 Homicide	building,	etc. (Specil	(y)				City or Fo	wn, Stete)		
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edicai ((Check only 2 Medical Exa	hysician: To the bes	of exemina	owledge, deel	th occurred at the	time, dete e	nd place,	, end due to the	cause(s) end	menner es	stated. to the cause(s)
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	Sta Registra	te	31. Date filed (Mooth Day, Year)	8 Sugar	skar's Signe	eture	y.	,					

Registrar DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death Month 17, 1998 Sharon L. Kern 4:40 PM JUNE 4a Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death RA Cowley Shock Trauma Center Baltimore Battimore If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 1□M 20F Months Days 49 234-04-9906 Oct. 4, 1948 West Virginia Usual Rasidance of Decedant 10c. City, Town or Location 10d. Inside City Limits 10a Stata 10h County 1 √ Yas 2 No W. Va. Jefferson Charles Town 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 115 Mordington Manor 25414 USA 14. Raca - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 No ff Yes, Give Yaar or Datas: 1 ☐ Navar Married 2 X Married 1 ☐ Yas 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 11 Restaurant Cook 18. Mothar's Name (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Annie Keesecker James Edwin Dunn, Sr. 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. fnformant's Name/Ralationship (Type, Print) 115 Mordington Manor, Charles Town, WV 25414 Ronald L. Kern, husband 20b. Place of Disposition (Nema of cematary, crametory or other placa) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 6/20/98 Sharpsburg, MD Samples Manor Cemetery 22. Name end Addrass of Facility 21. Signeture of Funeral Sarvice Licentum Eackles-Spencer Funeral Home on pications that caused the death. Do not anter the mode of Sying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or conshock, or heart failure. List only Approximata Interval Between Onsat and Death Shock Immediata Causa (Final disaasa or condition rasulting in daath) one week Dua to (or es a consequence of necrotizina 2 weeks Sequantially list conditions, if eny, leading to immediata causa. Enter Underlying Causa (Diseasa or injury that initiated avants rasulting in death) Last Dua to (or es a conseque 3 Weeks labial absass Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 1 Yas 2 No 25. Was casa refarred to medical axaminar? 26. Pleca of Deeth (Chack only ona) Hospital: 1 Inpatiant Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 2 ☐ Accident

Physician /Medical Examiner The law requires that the death certificate be axed

P.O. Box 68760.

Division of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, the Medical Examiner must be notified at

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any injury once.

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23.

altimore, Maryland 21215-0020

with the Maryland

Examiner Physician/Medicai Be

by Completed

attending physician and for use as the bunal-trans USB BS Medical Certification: To funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

3 Suicida 4 Homicide 29a. Certifier (Check only one)

5 Panding invastigation

6 Could not be datarminad

28e. Dete of Injury (Month, Day Year)

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)

1 ☐ Yas 2 ☐ No

28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta)

1 Certifying Physicfan: To the best of my knowledge, deeth occurred at the time, data and placa, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the best of my knowledge, deeth occurred at the time, data and place, and due to the ceuse(s) and mannar as stated. 29b. Signature app the of certifier

29d. Date signed (Month, Day, Year) JUNE 17, 1998

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

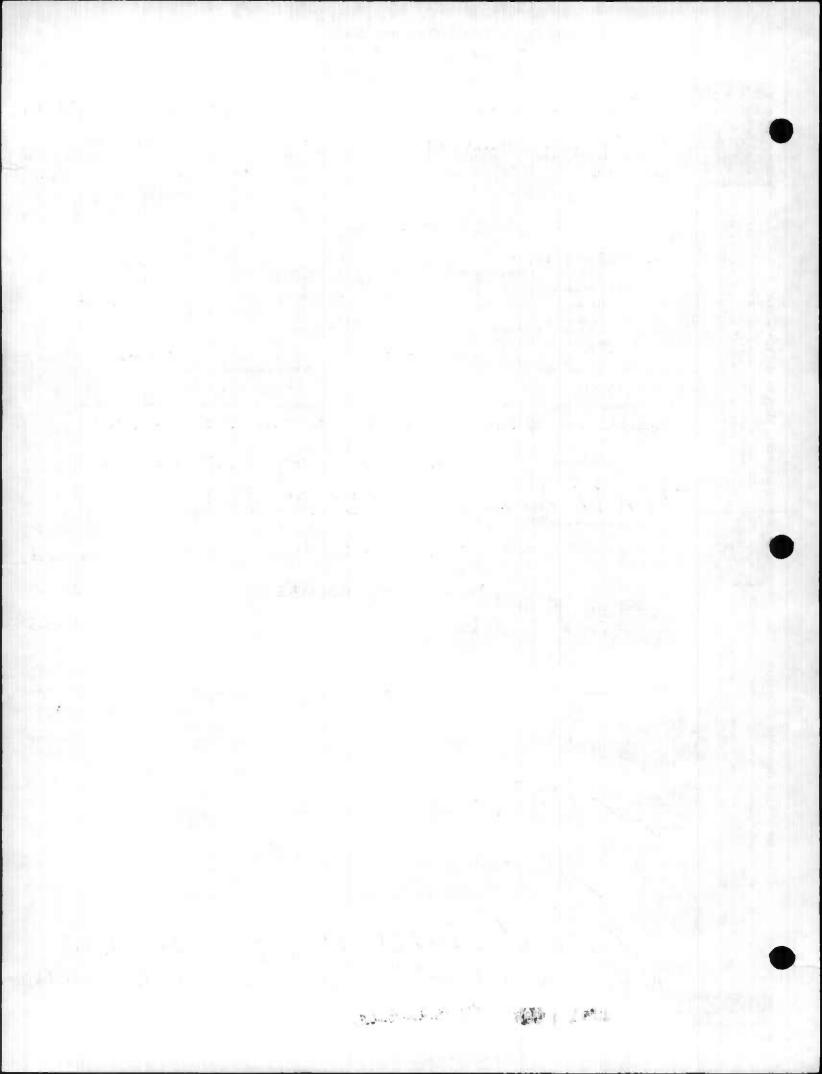
Angeleke Sariaaki S, MD 22

South greene Street, Baltimore MD

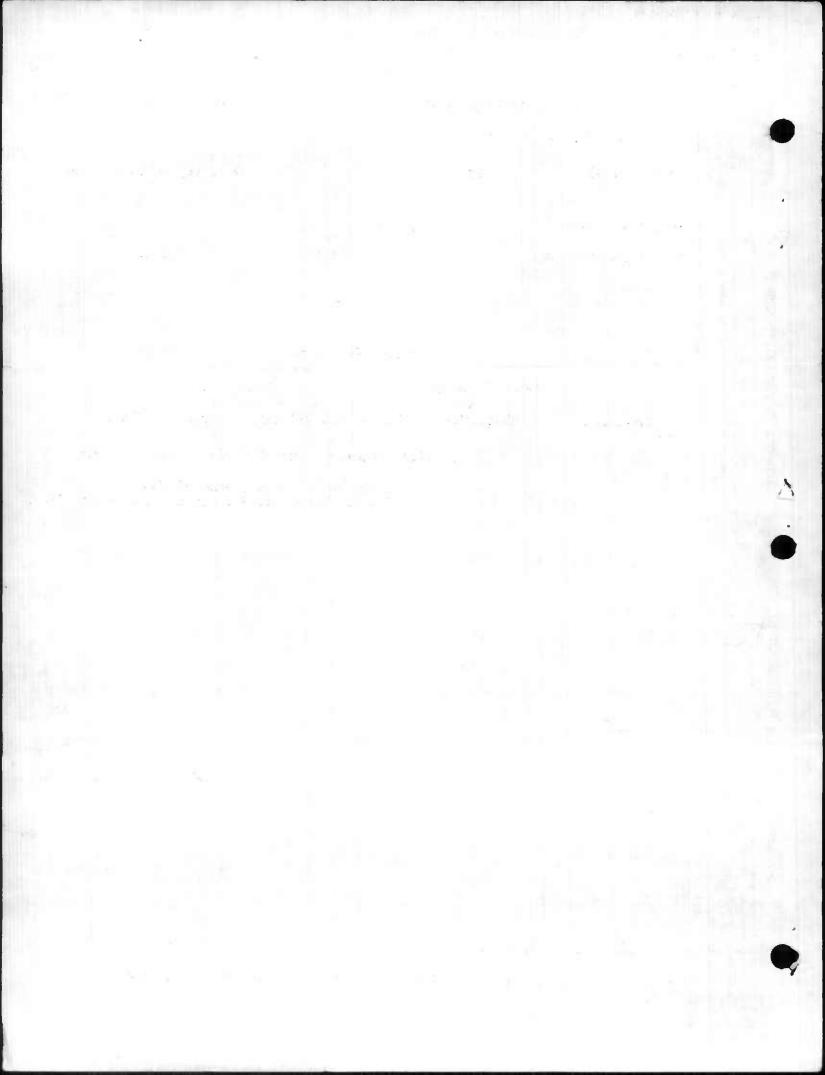
State Registrar 31. Data filed (Month, Day, Year)



After this



nysiçian Medical	Decedent's Nama (First, Middle, La					2. Data of D	eath	3. T	ime of Death		
		THOWAS KINNA	MON		b. City, Town, or L	Month JUNE	30, 1998	Year 20	006 PM		
xaminer	4a Facility Name (If not institution, given EASTON MEMORIAL				EASTON	ocation or Dea	th 4c. County TALE				
neral ector		Sex. 7. Aga (/n. 10. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7.	yrs. last birthde Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	1, 1920	9. Birthplace (S Country) Mary I an	Stete or Foreig d		
ם	10a. State 10b. County	100	. City, Town or	Location					ide City Limit		
Director	Maryland Talbot		Tilghn	nan					Yes 2 N		
Dire	10e. Street and Number			10f. Zip Code 2167			U.S.A.	Vhat Country?			
by Funeral Director	11. Marital Status 1 Naver Marriad 2 Married 3 Widowed 4 XDivorced	12. Was Decedant Evar Armed Forces? 1 Yes 2 No If Yes, Giva Yaar or Dates:	in U,S. 1	3. Was Decedant of H If Yes, specify Cuba 1 Yes 2X No		pecify Yes or No Rican, atc.)		e - American Ind k, White, atc. :: White			
Completed	15. Decedent's E (Specify only highast gr	ducetion ada completed)	/G	cedent's Usual Occup	during most of worl	working 16b. Kind of Busine		siness/industry			
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ပ္	10 17. Father's Name (First, Middle, Last))	Cital	rter boat		ne (First, Middle	e, Maiden Sumam	0			
To Be		Thomas F. Ki	nnamon		Vic	la Pri	ce				
-	19a. Informent's Name/Reletionship	and Number or Ru	rai Route Num	nber, City or Town, State, Zip Code) vland 21671 20c. Location - City or Town, State							
	Lorna Dutch	Companio		D. Box 322 sposition (Name of crematory or other place		-8					
- 1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	1998									
by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. — Due c. — Due d.	to (or as a con	sequence of):		23b. Dlo	d tobacco usa co		causs of dea		
Completed by						24a. Wa	s an eutopsy formed?	24b. Were au available completi of death	prior to on of cause		
Соп						O	Kes 2□No	1gRLYes	2 No		
Be	25. Was cese referred to medicei examiner?	Hospitai:	10/	oth all post Oth	26. Piece of Dea						
1: To	1 XXes 2 No 27. Menner of Death	1 ☐ Inpatient	2XER/Outpa 28b. Tim	tient 3L DOA	4 LI Nursing H		sidence 6 Oth how injury occur				
Certification:	1 ☐ Natural 5 ☐ Pending 2 🖾 Accident Investigation 3 ☐ Suicide 6 ☐ Could not	(Month, Day Yea on 6-30-98 28e. Place of Injury -	FOUND At home, farm,	7:02 ^M 1□	k? Yes 2∭No	28f. Location	SUBJECT FEL	L per or Rurel Rou	te Number,		
Cert	4 ☐ Homicide	RESIDENCE	oecify)			TILG	own, Stete) 5896 HMAN, MARYL	AND AND	OWN ROAI		
edicai		hysician: To the best of my miner: On the besis of exar and mannar stated.							ause(s)		
Medical Certifica	29b. Signature and title of certifier	Churte on		29c. Licens			29d. Data signe	d (Month, Day, 1	Year)		
	30. Name and address of person who			n Street,	Baltimore	e, Mary	land 212	01			



State of Maryland / Department of Health and Mental Hygiene

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tion			4	0

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** LILLIAN MARIE KNOTT JUNE 23, 1998 3:00 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE NURSING & REHABILITATION CENTER LARGO PRINCE GEORGE'S if Under 1 Year Months Deys 5. Sociel Security Number If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2XF Hours Director 577-01-2865 90 WASHINGTON, DC OCT. 6, 1907 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Director MARYLAND PRINCE GEORGE'S CHEVERLY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6208 KILMER STREET 20785 Funeral UNITED STATES deeth 12. Wes Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 2 No if Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examina 2008. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: þ 3 Nidowed 4 Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 SUPERVISOR TELEPHONE COMPANY 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ROBERT JAMES MEARS 2 MARGARET G. LONGWELL 19a. informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) DORIS GREMPLER, NIECE 7204 KIDMORE LANE, LANHAM, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 6/25/98 BRENTWOOD, MARYLAND FORT LINCOLN CEMETERY 22. Name and Address of Facility
FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 orios 1.00 cans Mrt1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediete Ceuse (Final disease or condition resulting In death) /Medical CEREBROVASCULAR ACCIDENT - DISEASE MAY 1998 Examiner Due to (or es e consequença of) Examiner CORONARY ARTERY DISEASE 1990 attending physician and for usa as the burial-transit certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that leitered exercises) Due to (or as a consequence of): Box 68760. HYPERTENSION 1980 Physician/Medical that initiated events Due to (or es e consequence of): resulting in deeth) Last P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed has certificate 1 Yes 1 Yes 2 No Division of Vital director, Be 25. Was case referred to medical exeminer? 28. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? Aftert Certification: or Attending 5 Pending investigation 1 Natural
2 Accident s efter death. 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of injury - At home, ferm, street, factory, office building, etc. (Specify) 6 4 Homicide Hospital 24 hours 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier edicai (Check only one) To the I within 2 To the F 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year)

D34722

JUNE 24, 1998

20710

30 State Registrar

VICKEN K. POOCHIKIAN, M.D., 5632 ANNAPOLIS ROAD, BLADENSBURG, MARYLAND 31. Dete filed (Month, Day, Year) JUN 26

32. Registrar's Signature

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

P		ite of Marylan	Certifica				Reg. No.) (1121
Physician	Decedent's Name (First, Middle, Last) Donald Kick	dwell, Jr.				2. Date of De Month JUNE		Year 998	3. Time of Death 0020 A
/Medical Examiner	4a Facility Nema (If not institution, give street of	and number)		4b	. City, Town, or	Location of Deat	4c. County	of Death	
ZXXXIIII	3621 SILVER PARK	DRIVE			Suitlar		PRINC	E GI	EORGES
Funeral	5. Social Security Number 6. Sex	7. Aga (In yrs. I	Monthe		If Under 24 Hrs Hours Min	(Month, De	th y, Year)	9. Birthpl Count	ace (Stete or Foreign
Director	Usual Residence of Dacedent	□F 22	115.			Dec. 11	, 1975	Vashi	ngton, D.C
show sdet	10a. Stete 10b. County		, Town or Location					10	Od. inside City Limits
ar and story	Maryland Prince Georg	e's F	orestville						1 ☑ Yes 2 □ No
or 28	10e. Streef and Number		10f. Z	ip Code			10g. Citizen of V	Vhat Count	try?
ral l	1918 County Rd. Apt.			207			United S		
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r, the Medical	15. Decedent's Education (Specify only highest grade comp	plated)	16a. Decedent's Us	ual Occupat	ion	nkina	16b. Kind of Bu	siness/Ind	ustry
a Mar	Elamantary/Secondery (0-12) Co	llaga (1-4or 5+)		_	iring most of wo		77 1		10 11 11
S S	12th 17. Father's Nama (First, Middle, Last)		Warehous			ma (First, Middla	Food		ce
Be	Donald Kidwell, Sr.					cia Jenl			
To	19a. Informent's Name/Ralationship (Type, Pri		19b. Maiting Addras	ss (Street er	nd Number or R	ural Route Numb	er, City or Town,	State, Zip	Code)
or train	Patricia Kidwell/ Mo	ther	1918 Cour	ty Rd	.Apt.T-	3 Fores	stville,	Md.	20747
important. It will \$1 is marked other than institute, any injury or other traumetic event, the Madical Exponent once. To Be Completed by	20e. Method of Disposition		lace of Disposition (Ne	ma of other plece)	Date	20c. Location -	City or To	wn, Stata
o ćun	1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)		. Lincoln	Cemet	ery	6/26/98	Brentwo	od, M	Id.
any inj	21. Signetury of Funeral Service Licen)	22. Name 8			e Funer	al Homoo		
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hysician end the burial-transit the burial-transit dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Causa (Disaase or injury	Dua to (or	r as e consaquence of):					
use as	that initiated events resulting in death) Lest	Due to (or	as a consequance of						
detached for	Part fl. Other significant conditions contributing	ng to death but not resu	ulting in the underlying	ceuse give	n In Part f.	23b. Did		ntributa to	the cause of death?
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page 2 should be dei							en autopsy ormed?	COL	ara autopsy findings allable prior to mpletion of ceusa daath?
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Be ad	25. Was cese rafarrad to medical axaminer?			- lau		eath (Chack only	one)		
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Completely filled in by the fune Medical Certification	one) ar	nd mannar stated.	11.00	9c. License					
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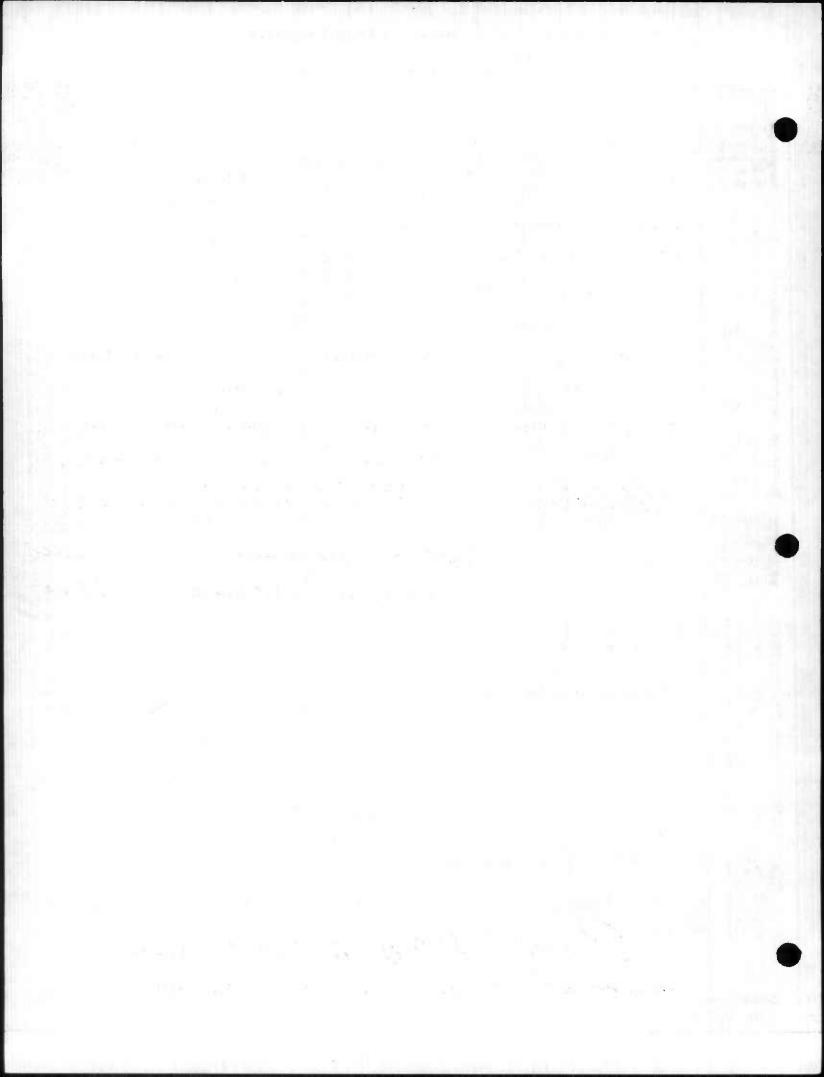
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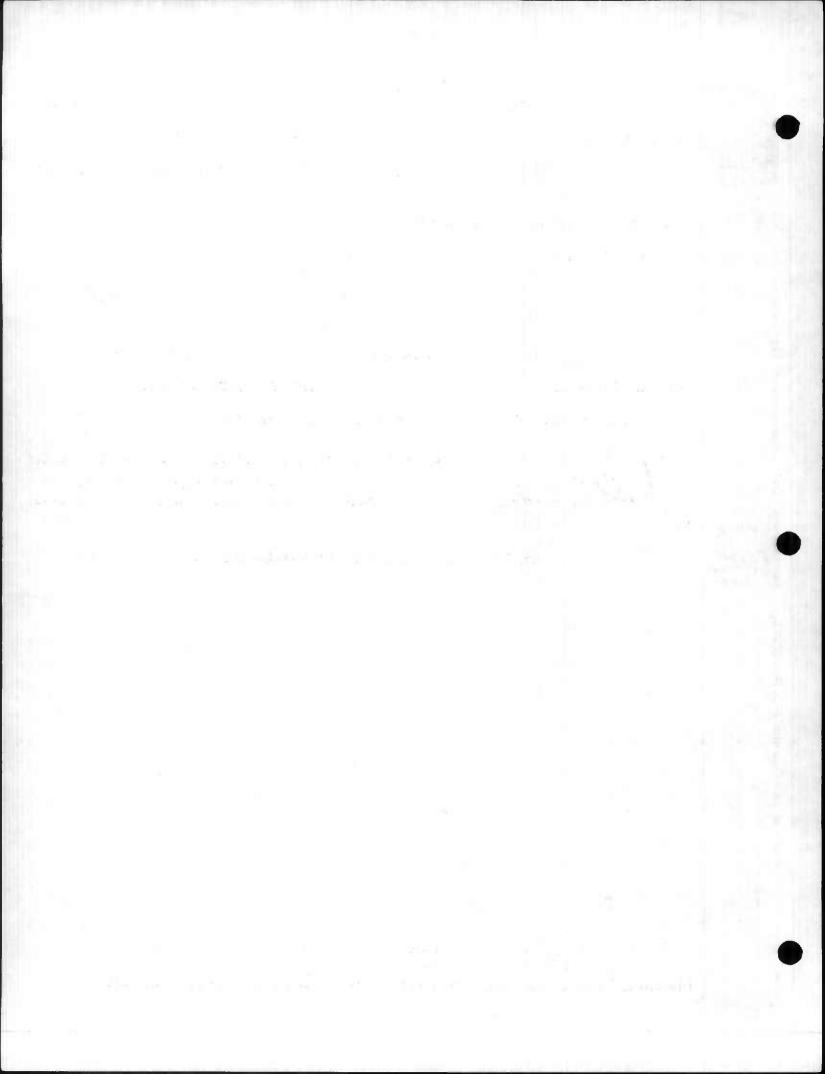
				State of Marylan	d / Department o Certificate of			giene Reg. No.	8	21128
			1. Decedant's Name (First, Middla, Last)				2. Date of De	ath Dey	Yeer	3. Time of Death
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	P R.		Usual Residence of Decedant 10a. Stata 10b. County	10c. City	y, Town or Location				11	Od. fnsida City Limits
	fath eggs	ō	Manus and Anna Ann		A 1					1 X Yas 2 No
	289 Double	Director	Maryland Anne Art	maeı	Annapolis	da		10g. Citizen of V	Vhat Coun	itry?
	ter death with the Maryland terms 23s or 28s-f show ther must be notified at		930 Astern Way Apt	. 310	21	401		US		
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yla	Merit arkan	10	Henry Lane			Jane	Hayes			
ar	2 sho and is ma		19a. Informant's Name/Ralationship (Ty	pe, Print)	19b. Mailing Addrass (St	reet and Number or R	ural Routa Numbe	er, City or Town,	Stata, Zip	Code)
, s	and m 27 her tr		Clarice M. Lane/ W	Vife	930 Astern	Way Apt. 3	10 Annar	olis, M	aryla	and 21401
ore	P T Test		20a. Mathod of Disposition 1 Ñ Burial 2 ☐ Cremetion 3 ☐ R	BINOVALIFORD STRIA	tiace of Disposition (Nama c ematary, cramatory or other		Deta	20c. Location -		
Ë	Mant The Man		4 ☐ Donation 5 ☐ Other (Spacify)	Dav	vidsonville U				dsonv	ville, Md.
Baltimore,	Depart Depart Import any in		21. Signature of Funeral Service Ligense	4		ddrass of Facility . Kalas Fu omons Isla			r Ma	21037
			23e. Part1. Enter tha disaasa, or compli shock, or haart failure. List only or	cations that caused the death	n. Do not antar tha moda of	dying, such as cardia	c or raspiratory a	rrast,	1	Approximata interval Batween
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funera	edical	29a. Certifiar (Check only one) 1XXCertifying Phys	sician: To the best of my kno- ner: On the basis of examinat and manner stated.	wledga, daath occurred at the tion and/or invastigation, in a	na tima, data and place my opinion, daath occ	e, and dua to tha urred at tha tima,	causa(s) and ma date and place,	annar as s and dua to	tated. tha cause(s)
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			1 / y cu	1/holl	/m /	72202	2-5-	June 1	0 10	108
			30. Nama and addrass of person who co	implated causa of death (item	23a) (Type, Print)		_	June 1	والسواد	70
			Paul S. Rhodes, M.		fton Centre	Crofton N	larvland	21114		
	Sta	te	31. Data filed (Month, Day, Year)	32 Registrar's Signa	tura	- VILLANI	and Jacobs	-1117		
	Registr	ar	JUN 12 19	198 Julia Davi	dson-Randell					
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	yland		10a. Stata 10b. County	10c. C	City, Town or Locat	ion				1	0d. Insida Ci	ity Limits
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	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?	
	ath w		102 GORDON LANE			21061			U.S.A.			
020	72 hours efter death with the Maryland "natural", or items 23s or 28s-1 show sdiest Examiner must be northed at	by Funeral	11. Marital Status 1 □ Navar Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Dacedant Evar in Armed Forcas? 1 1 1 2 1 1 2 1 1 2 1 2 1 1 2 1 2 1 2	u,s. 13. waa 942–1945 ^{Ya} 948–1952	s Dacedant of I as, specify Cub	Hispanic Origin? (S an, Maxicen, Puar Specify:	Specify Yas or No to Rican, atc.)		ce - Amaric ck, Whita, by: WHI'.	atc.	
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ore			20e. Method of Disposition 1 ☑ Burlal 2 ☐ Cramation 3 ☐		Placa of Disposition cematary, cremeter	on (Nema of ory or other pla	ce)	Date	20c. Location	- City or To	wn, Stata	
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Baltimore,	permit. Peges Department of Important: If is any injury or once.		21. Signatura of Funeral Sarvice Ligen	ade	22. N	ECOND	SINAVE.,S.W.	GLEN	FUNERAL BURNIE,	HOME MARY	,P.A. LAND 2	21061
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	within 2 To the comple	Me	29b. Signatura and titla of certifiar			29c. Licans	sa number		29d. Data signa	ad (Month,	Day, Year)	
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			30. Name and eddress of person who	emplated ceuse of deeth (Ite	em 23e) (Type, Prir	nt)						
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	Sta Registr			32. Registrer's Sign	netura Hdron-Rand	.92.	9	·				

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month RUSSELL LONG 22, 1998 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 130 Willowdale Drive Apartment 24 Frederick Frederick 7. Age (In yrs. last birthday) if Under 1 Year if Under 24 Hrs. Birthplace (Stata or Foreign Country) **Funeral** M 2□F Days Months 265-60-6887 56 Director May 8, Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at 1 Yes 2XXNo Director Maruland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? natural', or items 23s 12104 Tolley Terrace United States 21770 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American indian, Black, White, etc. permit. Pagas 1 and 2 should be filed within 72 hours eftar d Department of Haelih and Mental Hygiane. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 1 ☐ Yes 2 No tf Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: by 3 □ Widowed 4 □ Divorced White Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) + 4 Administrative Accountant General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) William Edward Long Sally Dykes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Floanna L. Long, wife 12104 Tolley Terrace Monrovia, Maryland 21770 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Remove from State 4 Donation 5 Other (Specify) 6/24/98 Hagerstown, Maryland Hagerstown Crematory 22. Name and Address of Fecility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick. MD a, or exhibiting that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, List only one cause operate line. **Physiclan** /Medical INFARCTION Immediate Causa (Final MYD CARDIAL IDAY Examiner Dua to (or as a consequenca of) Examiner Years HYPERTENS/ON The law requires that the deeth certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician at s the buriel-t Records, P.O. Box 68760, HYPERLIPIDEMIA Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed I Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital i or Attending Physician: after death. Director: After this certifica Be 25. Was casa raferred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, afc. (Specify) 4 Homicida Hospital or /
 24 hours aftar
 Funeral Directable filled in b 12 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date and place, and dua to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fund complately f (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) D43091 6-23-98 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) TOLL HOUSE AVE. 801 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Month Year **Physician** 21, 1998 6:45 P.M. June Frances K. Lewis /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** FREDERICK
If Under 24 Hrs. 8. 1
Hours Min. (FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Deta of Birth (Month, Day, Year) **Funeral** 1□M 2√F Months Deys Director 78 FEB.7,1920 219-14-7836 EMMITSBURG, MD Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or liente 23s or 28s-f show the Medical Examiner must be notified at 1 ¥ Yes 2 □ No Directo MD FREDERICK **EMMITSBURG** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? S. A.

14. Rece - American Indien,
Bleck, White, etc. 286 S. SETON AVE. 21727 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 11. Meritel Status 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE ğ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d other than ST. JOSEPH'S Elamantary/Secondary (0-12) College (1-4or 5+) 9 PROVINCIAL HOUSE LAUNDRY WORKER 18. Mother's Name (First, Middle, Maidan Sumeme) 17. Father's Neme (First, Middle, Last) Be Department of Health and Mental important: If them 27 is marked or JAMES M. KESSLER MARY A. BOWLING 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) ROSE MARY SHARRER/DAUGHTER 15335 SIXES RD., EMMITSBURG, MD. 21727 20a. Mathod of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other placa) Dete 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Othar (Specify) 6 NEW ST. JOSEPH'S 6/24/98 EMMITSBURG, MD. 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee kiles SKILES FUNERAL HOME Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feliure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician Perforation /Medical Immediata Ceusa (Final of Viscus diseese or condition resulting In deeth) Examiner Examiner Months Carcinoma 01 physician and the burial-transit Sequentielly list conditions, if any, laeding to immediata causa. Enter Underlying Ceuse (Diseese or injury that initiated evants resulting in death) Lest Dua to (or as e consequance of): P.O. Box 68760 Physician/Medical Due to (or es a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco usa contributa to the cause of death? been signed by t should be detact 1 Yee 2 No 3 Probably 4 Unknown arkinson's DISEASE Division of Vital Records. by 24b. Wara autopsy findings evalleble prior to completion of cause of death? Completed 24e. Wes en autopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 1 € Inpatient 2 □ ER/Outpetient 3 □ DOA Certification: To 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Panding or Attending efter death. Director: Aft 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicida To the Hospital within 24 hours e To the Funeral D 15 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medicat Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29e. Certifian Medical

State Registrar

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29b. Signatura and the contifiar

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30. Name and eddress of gerson who completed causa of deeth (Item 23a) (Type, Print)

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32. Registrer's Signeture John Shocker Restall 29c. License number

TOLL

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HOUSE

29d. Date signed (Month, Dey, Year)

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6-22 -98

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1998 **Physician** Month June 25, Hilda Louise LLoyd /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Health Care Center Frederick Frederick 8. Date of Birth (Month, Pay, Year) If Under 1 Year if Under 24 Hrs. | Months Days Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthpiece (Stete or Foreign **Funeral** Sex 1□M 20 F Months 215-42-3880 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nem z7 is marked other than "naturel", or items 23s or 28s-1 show other traumstic event, the Medical Examiner must be notified at Yes 2 No Frederick Director Md. Brunswick 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 224 Rean 9th Avenue permit. Peges 1 end 2 should be filed within 72 hours efter death v Department of Health end Mentel Hygiene. The processing from 27 is marked other than "natural", or flema 29a any injury or other traumatic avent, the Medical Example 2016. "natural", or itema 23a 21716 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2 No p 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Tunner Clinedinst Bentha Steadman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4303 Trego Road - Keedysville, MD 21756 Ruth E. Long, Daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition

1 Burial 2 ACremation 3 Removal from State Date 20c. Location - City or Town, State Hagenstown Crematory6/25/98 Hagenstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funcial Service Licensed

22. Name and Address of Facility

32. Name and Address of Facilit Approximate Interval Between Onset end Death **Physician** hronic Obstructive Palmenary Disease Immediete Ceuse (Final disease or condition resulting In death) /Medical **Examiner** Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed
the brought after death.
 Funeral Director: After this certificate has been signed by the estending physician end
letely filled in by the funeral director, page 2 should be detached for use as the burle-fransit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24e. Was an autopsy performed? 1 ☐ Yes No No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Wursing Home 5 Residence 8 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Mapper of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Casper E. Cline, III, MD 300 W. 9th Ave. Frederick, MD 21740

32. Registrar's Signature

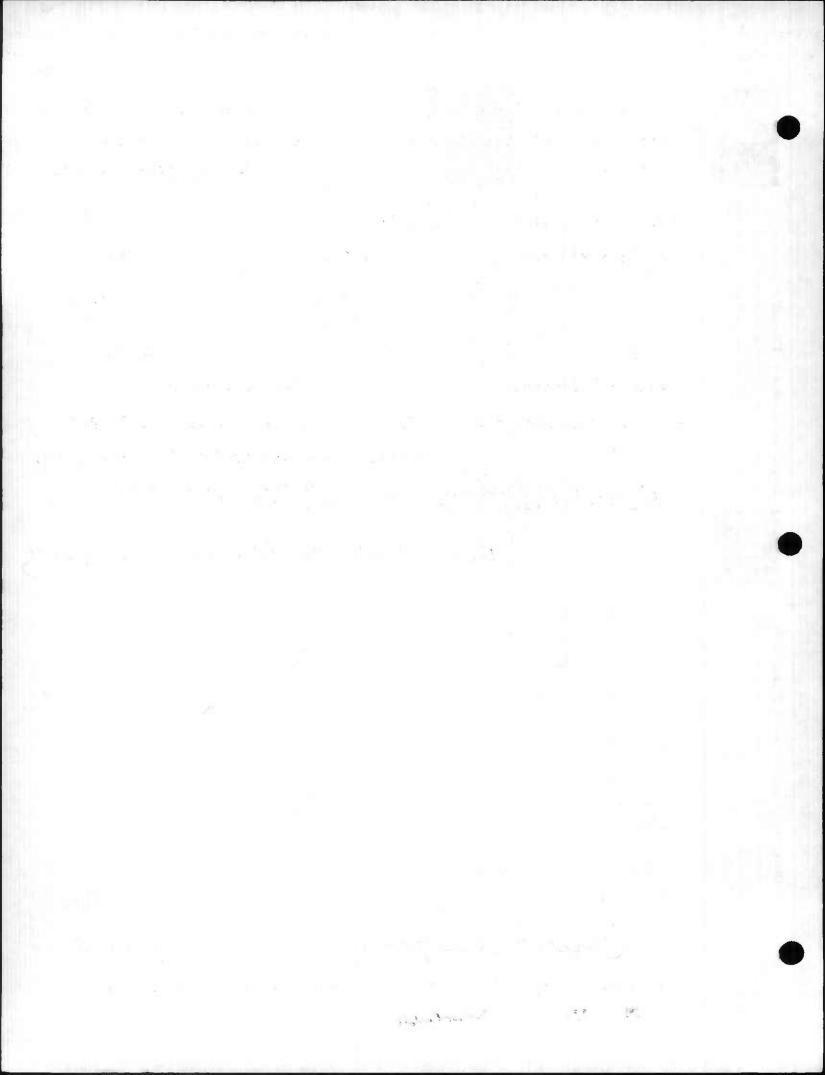
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31. Date filed (Month, Day, Yeer)

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Inju Wc actory, offica	iven in Pert I 26. Place ther: 4 Nu ury et ork? I'me, dete en opinion, dee onse number	CAR CAR e of Deeti	23b. Dld 1	tobacco use cover 2 No en eutopsymmed? Yes 2 No ene eutopsymmed? Yes 2 No ene) dence 6 Ot how injury occurs (s) end red place 29d. Date sign	Applinter Ons PISEA SE Ontribute to the several above or Rural Route to the several Rout	cause of de and Deet and Deet and Deet and Deet and Deet and Deet and Deet approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximate

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Name (First, Middle, Last) **Physician** Annie Μ. 1998 20 03:15 AM June * /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) Days 1 ☐ M 2 ☐ F Yrs. 245-58-3117 58 Oct. 30 1939 North Carolina Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits St. Mary's Maryland Mechanicsville 1 X Yas 2 No Director 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 37099 Asher Road 20659 United States 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16h Kind of Business/industry Elementery/Secondary (0-12) Collega (1-4or 5+) 11th Housewife Private 17. Fether's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) William Tillery Hattie Armstrong 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) James E. Lucas - Husband 37099 Asher Road, Mechanicsville, MD 20b. Place of Disposition (Neme of cematary, crametory or other place) 20c. Location - City or Town, State 20a Mathod of Disposition Burial 2 Cramation 3 Ramoval from State 6/24/98 Harmony Memorial Park Landover, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Sarvice Licensi 22. Nama and Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Entar the disease, or complications that caused the learn. Do not enter the mode of dying, such es cerdiec or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Deeth Immediete Ceusa (Final disaasa or condition resulting in deeth) Chronic Lymphatic Leukemia about 5 years Due to (or as a consequence of) Examiner Sequantially list conditions, if any, laeding to immediate cause. Enter Underlying Causa (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of cause of death? 1 Yes 2 No 1 Yas 2 No 25. Wes case refarred to medical axaminar? Be 26. Pleca of Deeth (Check only one) Hospital: 1 Yas 2 10 No Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 10 1 Pripatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28h. Time of 28c. Injury at Work? Certification: 5 Panding investigation 1 (Divature) 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcida 8 Could not be determined 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide

Box 68760

Funeral

Director

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2 should be filled within 72 hours effer nend Mental Hyglene. Is marked other than "natural", or ite

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permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m any Injury or other traum

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Examiner

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physician

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3altimore, Maryland 21215-0020

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death

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ANNIE MORRIS A 24 hours To the within 2

Medical State

Registrar

MOHAMMAD A. RAHMAN, M.D. 31. Data filed (Month, Day, Year) JUN 2 3 1998

29a, Cartifian

(Check only one)

29b. Signatura and titla of certifiar

DR.M.A. Rohman, ND

D50044

29c. Licansa number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as steled.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Data sloned (Month. Dav. Year) 06/20 1998

30. Nama end address of person who completed cause of daath (Itam 23a) (Type, Print)

PO BOX 640 HOLLYWOOD, MD 20636

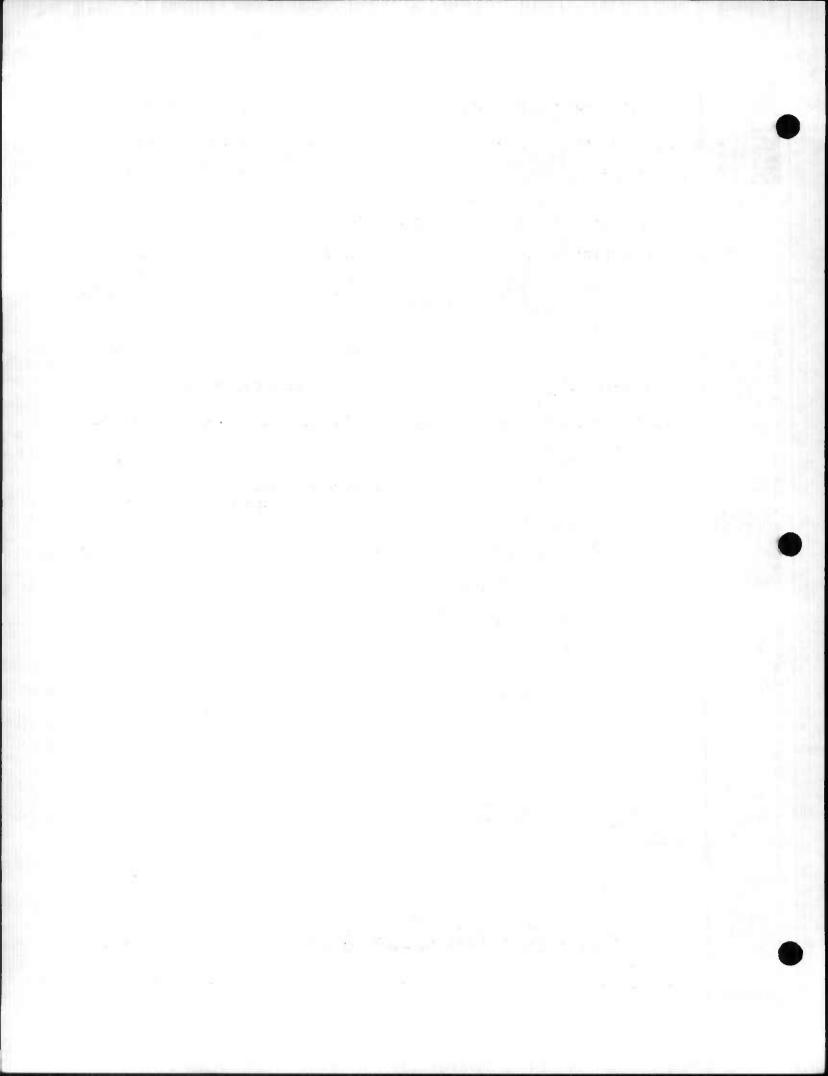
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Richard Edward Logan, Sr. 5:28 PM 28, 1998 June /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Prince Frederick Calvert Calvert Memorial Hospital Hours Min. 8. Date of Birth (Month, Dey, Yeer)
July 3, 1939 If Under 1 Year Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□ F Deys 58 Yrs Director 219-34-7825 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 Yes 2 No Director Charles Maryland Hughesville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ 6290 Swan Harbour Ct. 20637 items 23a USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Xes 2 ☐ No 11. Maritei Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Peges 1 and 2 should be filed within 72 hours efter inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "naturel", or ite 1 Never Married 2XX Married Baltimore, Maryland 21215-0020 Yeer or Dates: 7/56-12/56 Yes 2 Xio Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Marine Engineer Merchant Marine 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Gregg Robert Logan Rhoda Cecilia Coomes 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 s Department of Health er Important: if Item 27 is eny injury or other trau Doris M. Logan - Spouse 6290 Swan Harbour Ct., Hughesville, MD 20637 20b. Plece of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory Waldorf, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility
Huntt Funeral Home, Inc. Y hou M00053 Mark G. Brohawn P. O. Box 156, Waldorf, MD 20604-0156 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediete Cause (Final Fabrosic Ulmman diseese or condition resulting in deeth) Examiner Examiner Failure The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Pert ii. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Be Completed 24e. Wes en eutopsy performed? pege 2 s certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

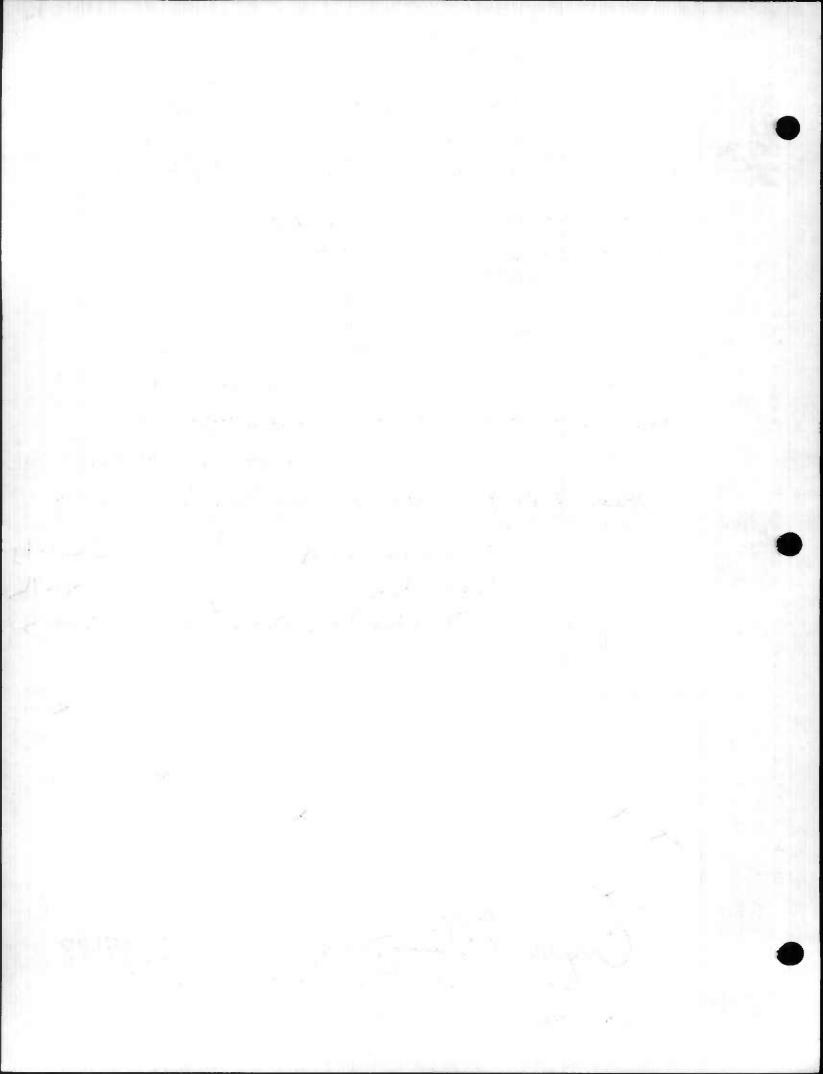
To the Funeral Director: After this certifica completely filled in by the funeral director; s 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) 1 ☐ Yes (☐ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medicai Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Da 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred (□ Natura 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Dertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steled. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Itospital Dr. Piru Frederick mes Brodes M.A., 110 - Michael 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Juli Davelor Randall Registrar JUN 3 0 1998



State of Maryland / Department of Health and Mental Hygiene

						Certific	ate of	Death		R	leg. No.	20	Com 8 8	00
			1. Decedent's Name (First, Middle, L.	rst)						2. Date of Dea	th		3. Time of	Death
	Physic			Margaret	Louise	MULL	ICAN			June 1	18. Day	1998	9:45	P.M.
	/Medl Examir		4a. Facility Name (If not institution, gi			-		4b. City, To		ocation of Deeth	-	nty of Death	, , , ,	
П	LAUTIN		Northampton Mar	or Nursing	Home			Frede	eric	k	F	reder:	ick	
Н	Funeral				e (In yrs. last birt		der 1 Year	If Under		8. Date of Birth (Month, Dey			place (Stete o	r Foreign
	Director		217-32-5790 Usual Residence of Decedent	1□M 2MूF	0.0	Yrs. Mont	hs Days	Hours	Min.	Sept. 1,	1917	Cour	yland	
	land		10a. State 10b. County		10c. City, Town	or Location							10d. Inside CI	ty Limits
	he Mary	Director		derick		Ton		rederio	ck				1∭ Yes	2 □ No
	ter death with the Marylan items 23a or 28a-f show instituted to collined at		116 South Jeff	erson Stre	et	101.	Zip Code 217	701			I0g. Citizen o	S.A.	ntry?	
020	n 72 hours efter death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Detes:			ecedent of specify Cut s 2 X No		gin? (Spi , Puerto	ecify Yes or No- Rican, etc.)	Spec	aca - Americ lack, White, pify: W		
2-0	72 ho	ted	15. Decedent's E (Specify only highest or	ducation	16a.	Decedent's U	Jsual Occu	pation	of work	ina	16b. Kind of	Business/în	dustry	•
21215-0020	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Homem		during most	OF WORK	nig	Ow	n Home	е	
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lany	d 2 should th and Men 7 is marks traumatic	To	19a. Informant's Name/Reletionship	Type, Print)			ress (Stree			al Route Number			Code)	
	and a salth n 27 l		Cheryl L. Mullic	an, Daught	er 8	West	Sever	ith St	reet	, Frede	rick,	MD 21	701	
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removel from State	20b. Placa of cemeter	Disposition (y, cremetory	Neme of or other ple	эсе)	i	Date	20c. Location	n - City or To	own, State	
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Bal	permit. Pag Department Important: h eny Injury o once.		21. Signature of Funeral Servica Lice	Ruby	M0070	Keen	ev &	Basfor	rd P	.A. Funereet, F	eral H	ome ck. M	D 2170	1
	100		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that aused one cause of each lin	the death. Do n	not enter the r	node of dy	ing, such as	cardiac (or respiratory arr	est,		Approximate Intervel Bet	9
d	Physician			~			_	_					Onset end I	-
1	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	a. >7	neu	mo	1	9				i	2 w	eet
		-	Tooling in abatily		Due to (or es e d	consequence	of):					I	110	· H
	uted	Examiner		b	Tro	KE							1000	nIL
68760,	ertificate be executed ling physician end e es the burlei-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	c	Due to (or es e c	5-6	TE	5 1	Mt	Mita	5		yes	115
×	E 0 0	n/Medical	resulting In deeth) Last	d										
. Bo	death se etter ad for u	sicia	Part II. Other significant conditions	contributing to death bu	ıt not resulting In	the underlyir	ng cause g	iven in Part I.		23b. Did to	obacco use d	contribute t	o the cause o	of death?
P.0	es that the death cer igned by the ettendin be detached for use	Physician								1□ Y	es 2 No	3 Pro	bably /	Unknown
Records,	aw requir	Completed by					٠			24a. Was e perform		av	ere autopsy f vallable prior to impletion of c death?	0
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Division	Attender deat ector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	00- 01(1-1-	iry - At home, far	m, street, fac		Yes 2 l		28f. Location (Si City or Town		n <i>ber</i> o <i>r Run</i>	al Route Num	ber,
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	To t To t	Σ	29b. Signature and title/of certifier	4	//-	100	29c. Licen	se number	(- /	2	9d. Date sign	ad (Month,	Day, Year)	
3			30. Name end eddriffs of person who	V (unth (llean coast of	4 161	mi	701	0	198	0	11	178	
				e, III, M.			Ninth	Stree	et, l	Frederic	k, MD	21701		
	Sta		31. Date filed (Month, Day, Year)	32. Registre	r's Signature									-
	Registr	ar	JUN 2 2 19	98 Min	Davidson A	arballi								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month 21°, 1998 Juliana Berbee MENS 9:35 pm June /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Aug 7, 1916 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Days 1 □ M 2 1 F Hours 152-62-5716 Yrs. 81 Director Netherlands Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inalde City Limits rs!', or items 23a or 28a-f shore Examiner must be notified at Maryland Frederick Frederick 1 Yea 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Burgess Hill Way, B-100 21702 Netherlands Funeral Peges 1 and 2 should be filed within 72 hours after death nent of Health end Mental Hygiene.
snt: If item 27 is marked other than "nature!", or itema 23 ury or other traumatic event, the Medical Examples in the managed. 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Race - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1□ Yes 2□ No à Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker 8 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacobus BERBEE Wilhelmina Allegonda DeKort 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) George F. Mens/Husband 100 Burgess Hill Wat B-100, Frederick, MD 21702 20b. Place of Disposition (Name of ST. JUHNS CEMETERY 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department o important: If any Injury or JUNE 25 1998 FREDERICK MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility
Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service Licensee G Dem M00706 nym 106 East Church St, Frederick, Maryland 21701 Part1 Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardlec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Intracranial Hemorrhage Hours Examine Due to (or as a consequence of): Examiner buriei-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest Due to (or es a consequence of): Physician/Medicai the Due to (or as e consequence of): for use signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown 2 24b. Were autopsy findings Completed 24e. Wes en autopsy aveilable prior to completion of cause of deeth? page 2 certificate 1 Yes 20 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director. 8 25. Was case referred to medicel axaminer? 26. Place of Death (Check only one) Hospital: 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Metural efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital
 24 hours
 Funeral C 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26660 June 23, 1998 du approve to 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Marc Raphaelson, M.D., 801 Toll House Avenue, #HU6, Frederick, Maryland 21701 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

Box 68760

Division of Vital Records, P.O.

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State of Maryland / Department of Health and Mental Hygiene 98 21138

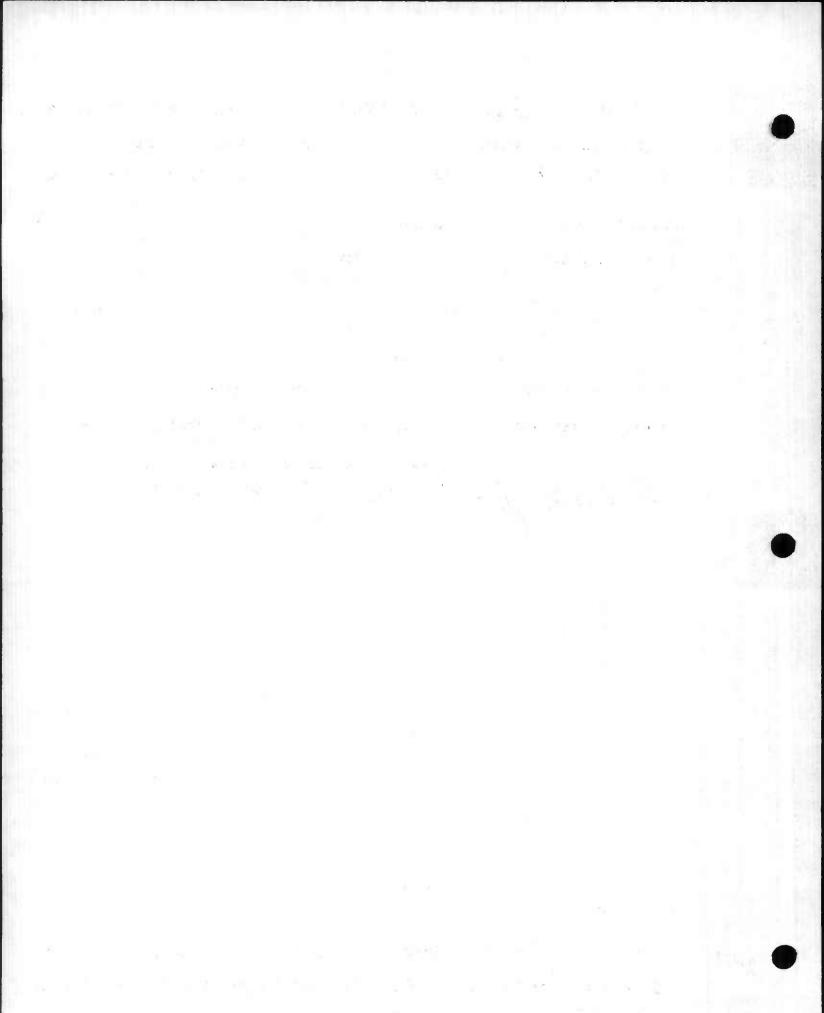
						Ce	rtificate of	f Death		Reg. No.		-1100
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Z	2 should by and Mente is marked numetic or	= -	Albert McCle 19e. Informant's Name/Relationship (19b. Mail	ing Address (Stre	et and Number or R	cil Kel	-	State. Zii	Code) 20910
\S			Elaine T. McCle		Wife			wick Lane				20710
e,	ges 1 and of Heal	1	20a. Method of Disposition		20b. P		osition (Name of imatory or other p		Date	20c. Location -	_	
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Ö	after Dire d in b		4 ☐ Homicide	build	ing, etc. (Specif)	v)			City or To	own, State)		
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	(0)		30. Name end address of person who	completed cau	se of death (Item	3 (Type	Print)	NT RAIN	NER	MARYLA	UM	20712
	State	а	31. Date filed (Month, Day, Year)	32 1	Registrar's Signa	ture	,	/ (/ 11 /		1011		
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State of Maryland / Department of Health and Mental Hygiene

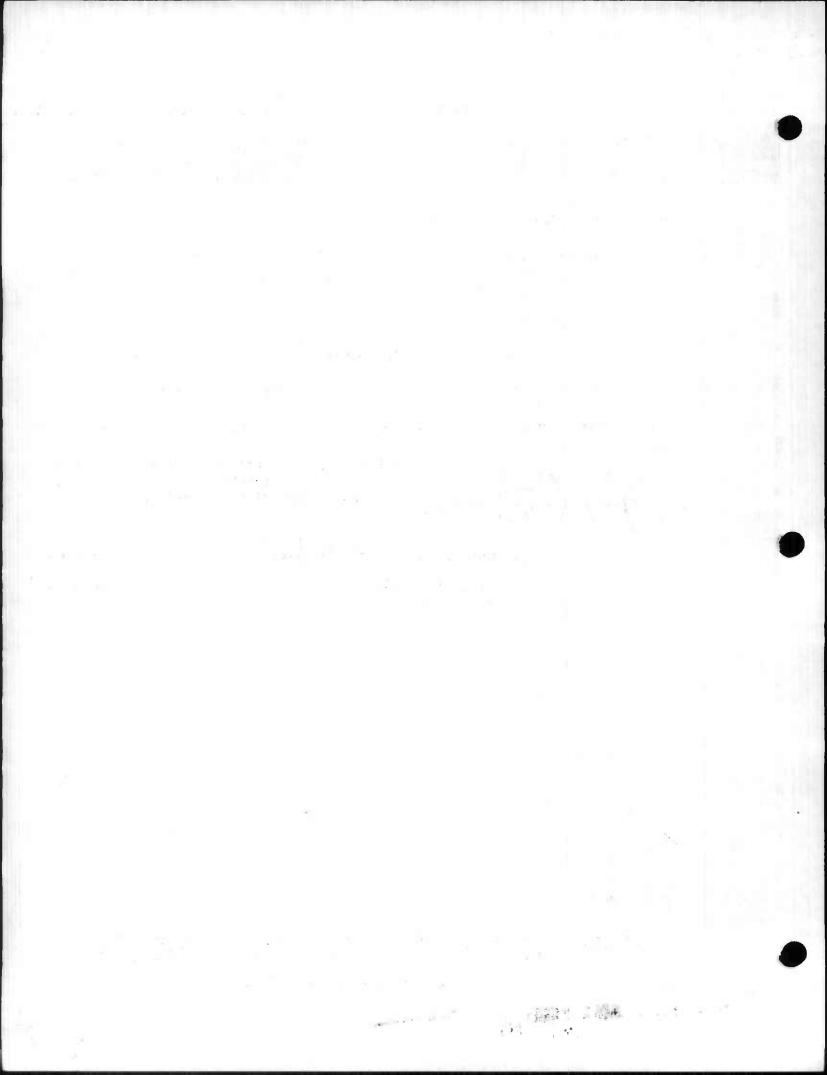
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State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate o	t Deati	n		Reg. No.		
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-			Citizens N	ursing Ho	me			Fr	eder	ick	Fre	deri	ck
H	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yes	ar If Unde	er 24 Hrs.	8. Date of Bir (Month, Da			lace (State or Foreign
	Director		214-48-2702	1□M 2Å□F	93	Yrs.	Months Day	's Hours	Min.		y, Year) 26, 1903	Coun	ryland
	D		Usual Residence of Decedent							Julia	20, 170,	, IId.	Lyland
	how		10a. State 10b. County		10c. City	y, Town or Lo	ocation					1	0d. Inside City Limits
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	h th	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of \	Whal Cour	ntry?
	h wil		5922 Bartons	ville Roa	d		217	701			United	State	es
	72 hours after death with the Maryland "neturel", or items 23a or 28a-f show adical Exacother must be notified at	Funeral	11, Marital Status	12. Was Dec	cedent Ever in U.	S. 13.	Was Decedent o		Origin? (Sp	pecify Yes or No		e - Americ	an Indian,
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Maryland	S DEE	-	19a. Informent's Neme/Relations	hip (Type, Print)		19b. Mailie	ng Address (Stre						Code)
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re	of Healt of Healt litem 2 r other		20a. Method of Disposition		20b. P	lace of Dispo	osition (Neme of matory or other p		Noau	Date	20c. Location -	City or To	wn, State
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			francisco de la company	K. ()	(were)							MD	21702
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Division	or Attending latter death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 288. Place	a of Injury - At ho ling, etc. (Specify		reet, factory, offic	8		28f. Location (City or To	Street and Numb wn, Stete)	er or Rura	I Route Number,
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			ROBERT L. KAUFM	ANN, M.D.	. 300 WE	ST 9TH	STREET	, FREI	DERIC	K, MD 2	1701		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12, 1998 1330 ELIZABETH ANN NACHLAS June /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Death Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 1 Year If Undar 24 Hrs. Hours Min. Birthplaca (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days 1 M 2 F NIA Yrs Director 23 June 10, 1998 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturet", or items 23s or 28s-f shov traumatic event, the Medical Examinat must be notified at tXYas 2□No Directo MARYLAND FREDERICK FREDERICK 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 98 HARRISON COURT USA death Funeral Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, Whita, etc. a filed within 72 hours efter al Hygiena. other than "naturel", or ite 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à Specify: WHITE 3 Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) N/A N/A NIA 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 12 should be finand Mental Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fisher Fis RACHEL ANN RODGERS Lo ARTHUR RICHARD NACHLAS 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pagas 1 end 2 st Department of Health and important: If item 27 is n any injury or other traun 98 HARRISON COURT, FREDERICK, MARYLAND 21702 RACHEL ANN NACHLAS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pagas 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery 6/22/98 Pt. of Rocks, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facilit ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 death. Do not enter tha mode of dying, such as cardiac or respiretory errest, Approximete Intervai Between Onset and Death **Physician** /Medical Immediate Cause (Final EXTREME PREMATURITY 48 hours disease or condition resulting in death) Examine Due to (or as e consequence of). Examiner RESPIRATORY DISTRESS 48 hours sician end buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in death) Last Due to (or as a consequence of): 24 hours HYPOTENSION physician the buriel Box 68760 Physiclan/Medical Due to (or as a consaguance of): 24 hours METABOLIC ACIDOSIS ed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 | Yes 2 No 3 □ Probably 4 □ Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy performed? complation of causa of deeth? 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificata 25. Was case referred to medicel 26. Place of Death (Check only one) Hospitai: 1

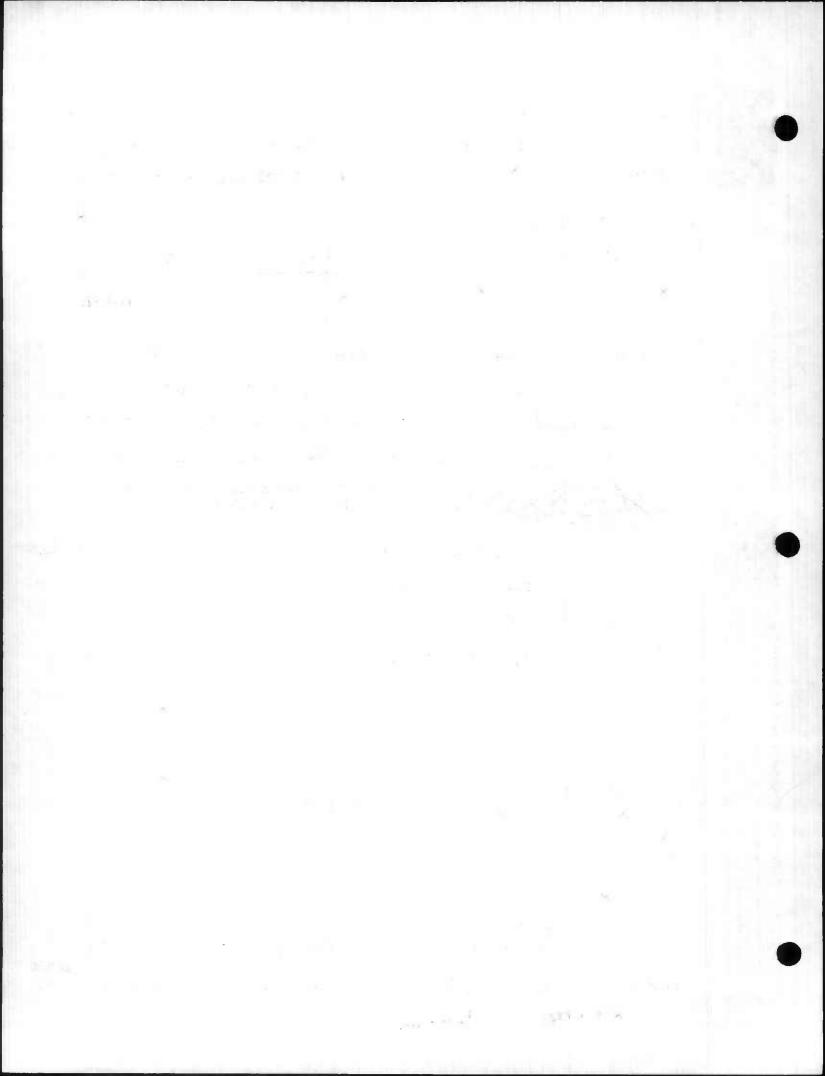
Inpatient 2□ ER/Outpatient 3□ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: i or Attending P efter death. Director: After i After 1 Naturai 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D complataly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) end menner es steted.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end piece, and due to the ceuse(s) and menner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. Licanse number 29d. Data signad (Month, Day, Year) June 15, 1998 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) BUCZEK, MD NEONATOLOGIST, 9901 Medical Center Dr., Rockville MD

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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State of Maryland /	Depa	rtment o	f l	Health	and	Mental	Hygien	e
			_	_	-			

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev Year **Physician** 1998 8:35 P.M. Bernice Ellen Nottingham June 21 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Cheverly Prince George's Prince George's Hospital Center If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Yrs. 93 Director January 23, 1905 Baltimore, Maryland 203-16-5988 Usuei Residence of Deceden 72 hours efter death with the Maryland 10a Stete 10c City Town or Location 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examinar must be notified at 10b. County 10d. Inside City Limits 1 Yes 2 □ No Directo Maryland Prince George's Landover Hills 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7003 Taylor Street 20784 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritei Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 □ Never Merried 2 □ Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: b 3 X Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) oe filed within 7 iel Hygiene. Lancaster, Pennsylvania Elemantary/Secondary (0-12) Collage (1-4or 5+) County Government Extension Librarian 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked of any Injury or other treumatic eve Mary Ellen Booth Harry Burton Schutz 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Raiationship (Type, Print) Ann Kelsall - Daughter 7003 Taylor Street, Landover Hills, Maryland 20784 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremetlon 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 6/23/98 Alexandria, Virginia Metropolitan Crematory 22. Name end Address of Fecility
Gasch's Funeral Home 21. Signeture of Funeral Sarvice Licensee 4739 Baltimore Avenue, Hyattsville, Maryland 20781 onstance 23a. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete tntarval Batween Onset and Deeth **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical neumonia Examiner Due to (or es e consequence of) Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of)

physician and s the buriel-transit The law requires that the death certificete be executed 50 signed by the a Deen hes

Physician/Medicai

by

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Certification:

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Box 68760.

P.O.

Division of Vital Records,

page 2 this certificate or Attending Physician: director, funeral After t deeth. Director: A

Part tt. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t.

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engestivo Heart Failure.

Due to (or es a consequence of)

Altradentia fibrillation

25. Was cese raferred to medicel exeminer? 1 Yes 2 No 27. Manner of Deeth 1 Naturel

5 Panding investigation 6 Could not be

Hospitel: 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Data of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 Tyes 2 No 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

28d. Describe how injury occurred

24a. Wes an autopsy performed?

1 ☐ Yes 2 ☐ No

(Check only one) 29b. Signeture end title of certifier

2 Accident

4 Homicida

3 ☐ Suicide

29e. Certifier

29c. License number D48213 29d. Date signed (Month, Dey, Year) 6-22-98

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown

24b. Ware eutopsy findings eveilable prior to completion of cause of death?

1 ☐ Yas 2 ☐ No

30. Name and address of person who complated causa of death (itam 23a) (Type, Print)

FAHZA. M 4000 Milchelulle #220 Bonne 20716

26. Plece of Daath (Check only one)

Registrar

31. Dete filed (Month, Dey, Yeer) JUN 23 1998

32 Ragistrer's Signature Jaki Studior Roylall

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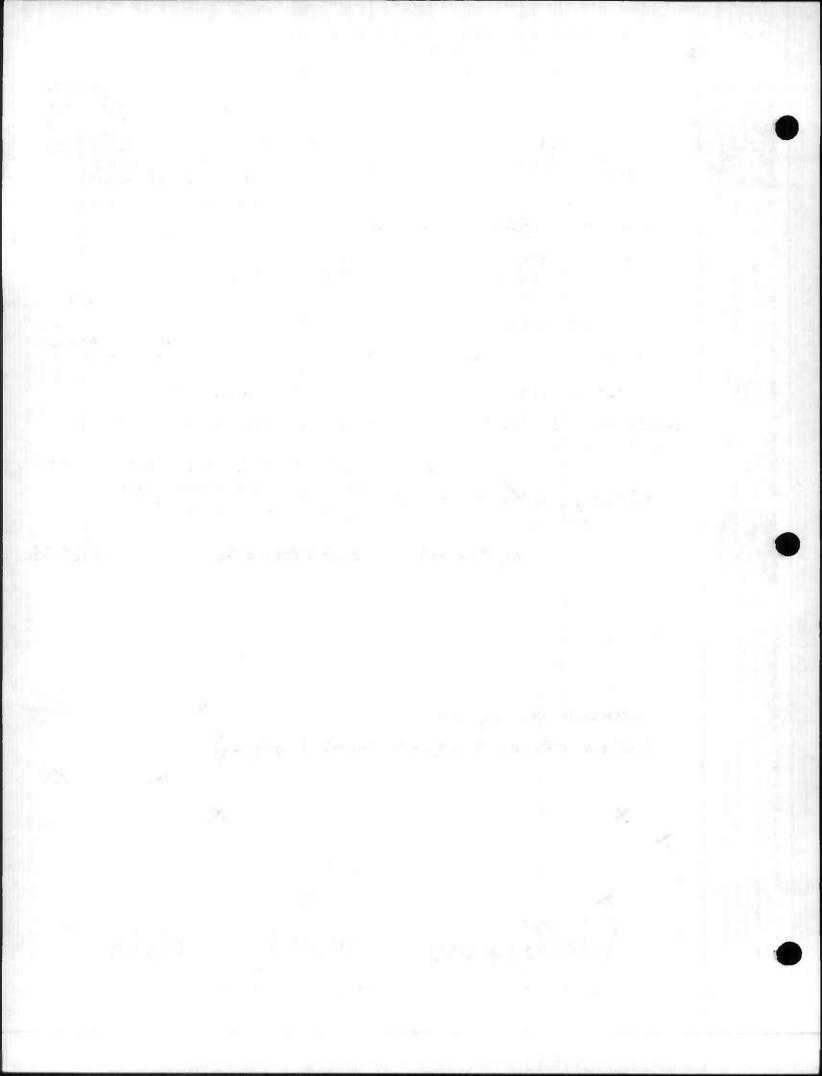
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permit. Page: Depertment or Important: If i any Injury or once.		21. Signatura of Funeral Service	e Licensaa	ns	22. Name and Addr THE HOUSE 411 KENNE	OF WILLI				
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or or or or or or or or or or or or or o	2	29b. Signature and titla of certif	nmed	A. Mw	Man De	2459	3	6.2e	, C	9 8
(2)		30. Name and address of parso	n who complated causa of	daath (Item 23a)	(Type, Print)),				the second
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	Funeral		5. Social Security Number 6. Sex		lest birthday)	If Under 1 Yes		8. Dete of Birth (Month, De)	Veer	9. Birthplace	Stete or Foreign
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<u>y</u>		2	PAASCHAL W	OODS			MARY	EMMA T	ODD		
Maryland	d 2 should in and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Meilir	g Address (Stre	et e <i>nd Nu</i> m <i>ber or R</i> u	irel Route Numbe	r, City or Town,	Stete, Zip Code	,)
			DALLAS PACE JR.	(SON)	105	DOMINO	E RD. Al	NNAPOLI	S, MD.	21401	
ore	of Haal frem 2 r other		20a. Method of Disposition		Piece of Dispo	sition (Neme of netory or other p	lece)	Date	20c. Location -	City or Town, S	tate
Baltimore,	Paga nat o nt: If		1 ⊠Buriai 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		HILL C	י דפיד ר	EMETERY	6/11/0	Q ANNA	PALIC	MD
alti	Departman Important: any Injury		21. Signature of Funeral Service License			. Name and Add		<u> </u>	O ANNA	rours,	_ ND.
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_6	be executed ician and burial-transit	Xa	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a conseq	uence of):					
760,	ta be ex ysician ne buria	ical	Cause (Disease or injury that initiated events							1	
687		edic	resulting in death) Last	Due to (d	or es e conseq	uenca of):					
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Box	atten	Physician/M									
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ecords,	S 5 5	l by	CANZER O		_			24 Was		Odb Maraia	stames directions
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/ita	Physician: The this certificata ral director, pag	Be	25. Was case referred to medical examiner?					oth (Check only or	ne)		
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U C	ter th		27. Manner of Death 1 Natural 5 Pending	28e. Date of Injury (Month, Dey Year)	28b. Time of tnjury	28c. Inj	jury at /ork?	28d. Describe h	ow Injury occurr	ed	
Ö	ath.	atle	2 Accident investigation	-35, 77, 752,	,,		☐ Yes 2☐ No				
Division of Vital	Afte ar de by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury · At h building, etc. (Specil	ome, farm, str	et, factory, offic	a	28f. Location (S City or Tow	treet end Number	er or Rural Rou	te Number,
Ö	a after	Cer		building, etc. (Opecin	97			ony or vow	,, 0.0.0)		
	hour hour mere ly fills		29a. Certifier Certifying Physi	ctan: To the best of my kno	wledge, deeth	occurred at the	time, date and place	, and due to the o	ause(s) and me	nner as stated.	
	To the Hospital or Attending Phywithin 24 hours aftar death. To the Funeral Director: After this complately filled in by the funeral	edical	(Check only one) 2 Redical Examin	er: On the besis of examina end menner stated.	ition and/or inv	estigation, in my	opinion, death occu	rred et the time, o	late and placa, a	and due to the o	ause(s)
	To the To the Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex	Σ	29b. Signature and itle of certifier			29c. Lice	nse number		29d. Date signed	(Month, Dey,	Year)
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			30. Neme and address of person who cor	npleted cause of deeth (Iter	n 23a) (Type	Print)	0-01		-110		
							O ANTA DO	NTTC W	D 21/	0.1	
	Sta	te	PETER GRAZE 900 31. Date filed (Month, Dey, Year)	BESTGATE 32. Registrar's Signa		111E 30	O ANNAPO	лььо, М	U. 214	0.1	
	Registr		JUN 11 10	198 Julia Da	vidson-R	indelle					

DHMH 16 Rev 6/95

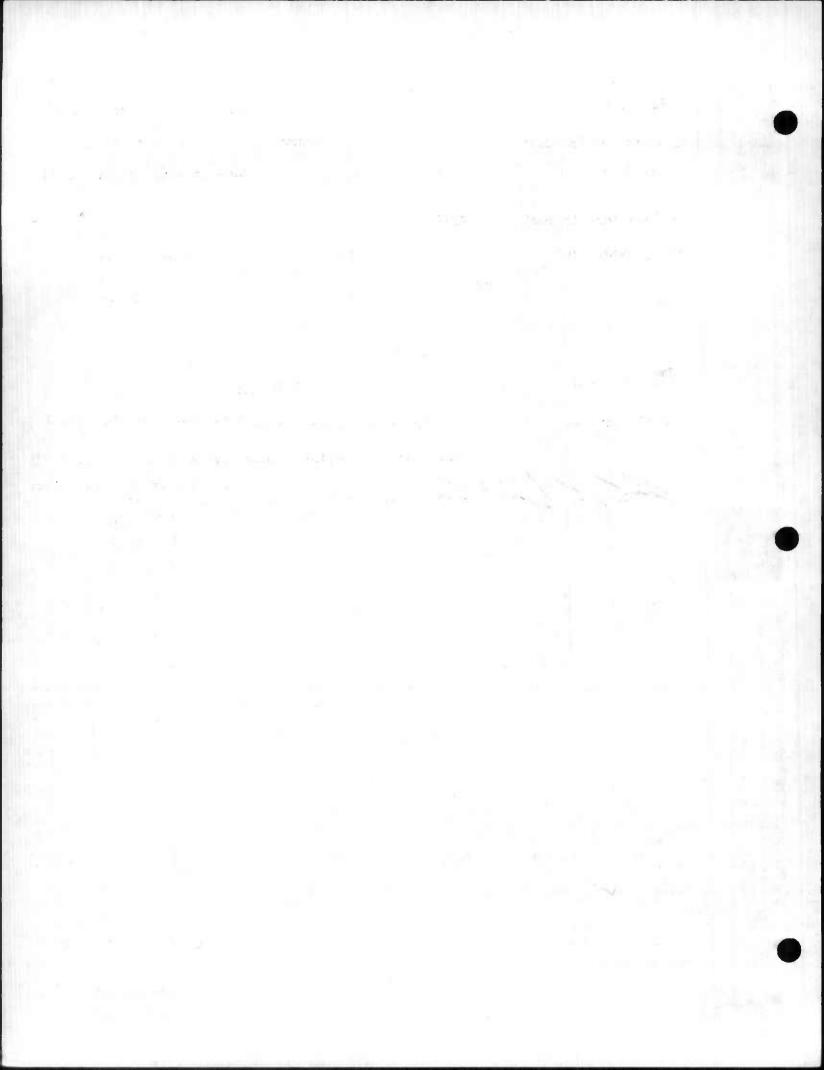


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State of Maryland / Department of Health and Mental Hygiene

					, , , , , , ,	C	ertifica	ate of	Death		Reg. No.	98	21165
	Division		1. Decedent's Nama (First, Middle	la, Last)						2. Data of D	aath	Walter	3. Tima of Death
	Physic /Medi		Eunice H. Peria	n						June	Day 4	Yaar 1998	6:45AM
	Exami		4a. Facility Nama (If not Institution	n, giva straat and numb	ar)				4b. City, Town, o	r Location of Daa	th 4c. C	County of Death	- 1 I W & ALA
			Magnolia Nursin	g Center					Lanham		Pri	nce Geo	orge
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	the Maryla 28s-f shor	St	Maryland Anne A	rundel	Bow	ie	Ţ						1 ■ Yas 2 □ No
	vith t	100	10e. Street and Number				10f. Z	ip Code			10g. Citiza	an of What Cou	untry?
	ath w	ra.	2200 Harwood La	ne				716				d State	es
	Herne Herne	P P	11. Marital Status	12. Was Deceda Armed Forca	57	,S. 1:	3. Was Dac	edant of h	fispanic Orlgin? (an, Maxican, Pus	Spacify Yas or N irto Rican, atc.)	0- 14	 Race - Amer Black, Whita 	
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e,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than eny injury or other traumatic event, its Monce.		Patricia Barrows	s / daughte	r	224	Sout	n Che	rry Gro	YE			ID. 21401
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Ξ	or Attending Pisather death. Director: After the in by the funera	Certification:	4 Homicide detarmi	inad 288. Place of I	njury - At ho atc. <i>(Specif</i>)	oma, farm, s	straat, fecto	ry, office			(Street and I wn, Stata)	Vumber or Rur	al Routa Number,
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			100	2			/	73	1/10	5	6/	4/55	>
			30. Nema and address of person v	who completed cause of	deeth (Item	23e) (Type	, Print)						
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Deeth July 28 中998 Year 2155 Adeline F. Potter 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth k Calvert Prince Frederick Calvert County Nursing Center If Under 1 Yeer 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 5. Sociel Security Number 113 05 5502 8. Dete of Birth (Month, Day, Year) Dec 4 1919 9. Birthpleca (State or Foreign Months Deys 1□ M 20XF New York Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Calvert 1 Yes 2 No Lusby 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? United States Thunderbird Drive 369 20657 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☑Yes 2 □ No If Yes, Give Yeer or Detes: WW I Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried white 1 Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) homemaker own home 12 17. Fether's Neme (First, Middle, Last) James Holland 18. Mother's Neme (First, Middle, Meiden Surname) Pettit Adeline 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Louise Sirmans- daughter 25 Edith Dr. Jacksonville North Carolina 28540 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta Arlington National July 7 1998 ington Virginia 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecilitikausch Funeral Home PA 21. Signature of Funerei Seprice Licenses 4405 Broomes Is. Rd. Port Republic Maryland 20676 23e. Pert1. Enter the disease, or complications that caused the duals. Do not enter the mode of dylng, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Immediete Cause (Finel disease or condition resulting in deeth) o (or es e consequenca of): Due to (or es e consequence of) Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? 1⊠Yes 2□ No 3 Probably 4 Unknown 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed?

Physician /Medical Examiner

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Funeral

Director

rel', or items 23s or 28s-f shore Exemples in the notified at

Pages 1 and 2 should be filed within 72 hours aftar of health and Mental Hygiena.
Int: If item 27 is marked other than "naturel", or ites
Inty or other traumate event, the Medical Experiment

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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daath with

iclan and burial-transit Physician/Medical Examin or Attending Physician: The law requires that the death certificate be assecuted physician s the buria should be d Completed page 2 certificata Be this funeral Aftar

Division of Vital Records. within 24 hours after death.

To the Funeral Director: A completaly filled in by the fu To the Hospital

P.O. Box 68760.

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. à 2 No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) 1 Yes 2 No Other: Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending 1 ☐ Yes 2 HNo Investigation 2 Accident 3 Suicide 8 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 29e. Cartifier Certifying Physician: To the best of my specifiedge, death occurred et the time, dete end piece, and due to the cause(s) and manner as steted. Medical Examiner: On the basis of manifestation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

PRINCE FREDERIK hel 20178

State Registrar

CALUERI

31. Dete filed (Month, Day, Year) JUN 3

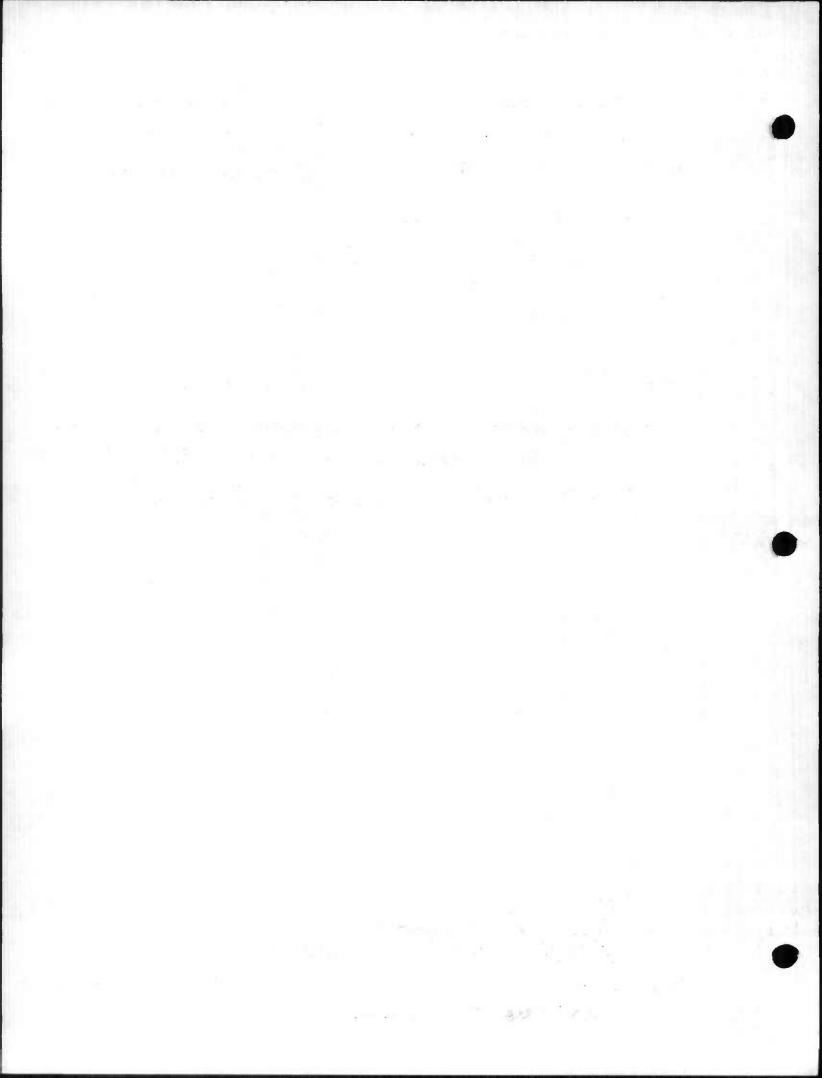
30. Name and educate of person who completed cause of deeth (Item 23e) (Type, Print)

Interno

- Medicine

32. Registrers Signature

A Java Churchan Randall



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State of Maryland / Department of Health and Mental Hygiene

cian		dent's Nama (First, Mide							2. Date of Do Month	Day		ear	ma of Death
ical	-	Lter Piecho							June	21	199		30 A.M
er		ity Name (If not institution			ber)			4b. City, Town, o	r Location of Deat				
	-	Nashville					if Under 1 Yea	Lanham r If Undar 24 Hi				George'	
	185-	Security Number	6. Sex	M 2□ F	'. Age (In yrs. 69	Yrs.	Months Day			ey, Year)	9. Pe	Birthplaca (S Country) ennsylv	ania
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	Mary!	Land Prince	e Geo	rge's	Lan	ham						N2	Yes 2□No
	10e. Stre	eet and Number					10f. Zip Code			10g. Citize	en of Wha	t Country?	
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	1	12				Photo	grapher					overnm	nent
	17. Fath	er's Name (First, Middle	e, Last)					18. Mother's N	ame (First, Middle	e, Malden S	(umame		
	Ar	ndrew Piech	owic	Z				Bertha	Filip				
	19e. inf	ormant's Name/Reletion	nship (Ty)	pe, Print)		19b. Meili	ng Address (Stre	et end Number or i	Pural Route Numi	ber, City or	Town, Sta	ite, Zip Code)	
	Rayı	mond Piecho	wicz	- Bro	her	414 T	imothy I	rive, El	izabeth,	Penn	sylv	ania l	5037
		thod of Disposition			20b. I	Place of Disponent	osition (Neme of matory or other p	lece)	Date	20c. Loc	ation - City	y or Town, St	ata
any injury or other poce.	Raymond Piechowicz - Brother 414 Timothy Drive, Elizabeth, Pennsylvan 20a. Method of Disposition 20b. Place of Disposition (Nome of cemptery, crematory or other place) 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place) 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery, crematory or other place 20c. Location - City of Competery 20c. Location									arvlan	d		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 Item#26 per Phy G762 8/10/98 EW State of Marylar Amend: #5,7,8,9,10e,13,14,19b Per FH Film G761 7-10-98RC Certificate of Death 1. Decedeni's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day **Physician** 2342 HRS Blanca Lilia Vivas Parra JUNE 21 1998 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION HOSPITAL ELKTON CECIL If Under 24 Hrs. 8. Date of Birth 1956 Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2MF Months 42 Yrs. RONDON, COLOMBIA Director AUG. 15, 1966 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show items 23a or 28a-f shov 1 Xes 2 No BOGOTA Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? CARREA # 166-42 APT. 305 COLOMBIA death Funeral 13. Was Dacadent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Dacedani Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, 11 Marital Status Black, While, etc the Medical Examiner 1 Yes 2 No Specify: COLOMBIAN 1 Never Married 2 Married Specify: HISPANIC Baltimore, Maryland 21215-0020 ò offiled within 72 hours of Hygiene. ò 3 Widowed 4 Divorced Year or Dates WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LEGAL ATTORNEY 5+ permit. Peges 1 and 2 should be filed v Depertment of Health and Mentel Hygie Important: if Item 27 Is marked other t 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) PARPA SOLER BERNARDA VIVAS CASTRO SALVADOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 45# 166-42 APT. 305, BOSOTA, COLOMBIA JOSE VIVAS CALDERON / HUSBAND CARREA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 ☐ Burial 2 M Cremation 3 MRemoval from State LAWNCROFT CREMATORY 6-26-98 LINWOOD, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility SPICER-MULLIKIN FUNERIC HOME 21. Signatura of Funerel Service Licensee HARVEY C. SMITH, JR. 1000 N. DUPONT HIGHWAY, NEWCASTLE, DE 19770 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Eic Approximate Intervel Between Onsat end Death Physician /Medical Immediate Ceuse (Final head and chest trauma MULTI disease or condition resulting in death) Examiner Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence ot): attending physician for use es the buna Box 68760, Physician/Medicai the Due to (or as a consequence of) P.O. I ed by the a detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown MOTOR VEHICLE ACCIDENT Division of Vital Records, þ 8 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy peen WITH EJECTION page 2 s 1□ Yes 20No 1 TYes 2 No. After this certificate or Attending Physician: Be director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 █ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 0 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending Investigation *1 Natural Injury 2335 PM death. 1 Yes 2 No MOTOR VEHICLE ACCIDENT JUNE 21, 1998 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) efter 4 ☐ Homicide To the Hospius within 24 hours efter To the Funeral Dir INTERSTATE CECIL COUNTY NB MILE MARKER 1 Certifying Phyalclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. edicai 29a. Certifier (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licanse numbar 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) SHAWN Α. CARNEVALE UNION HOSPITHC - ELKTON 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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State

Registrar

JUN 3 0 1998

relia Davidson

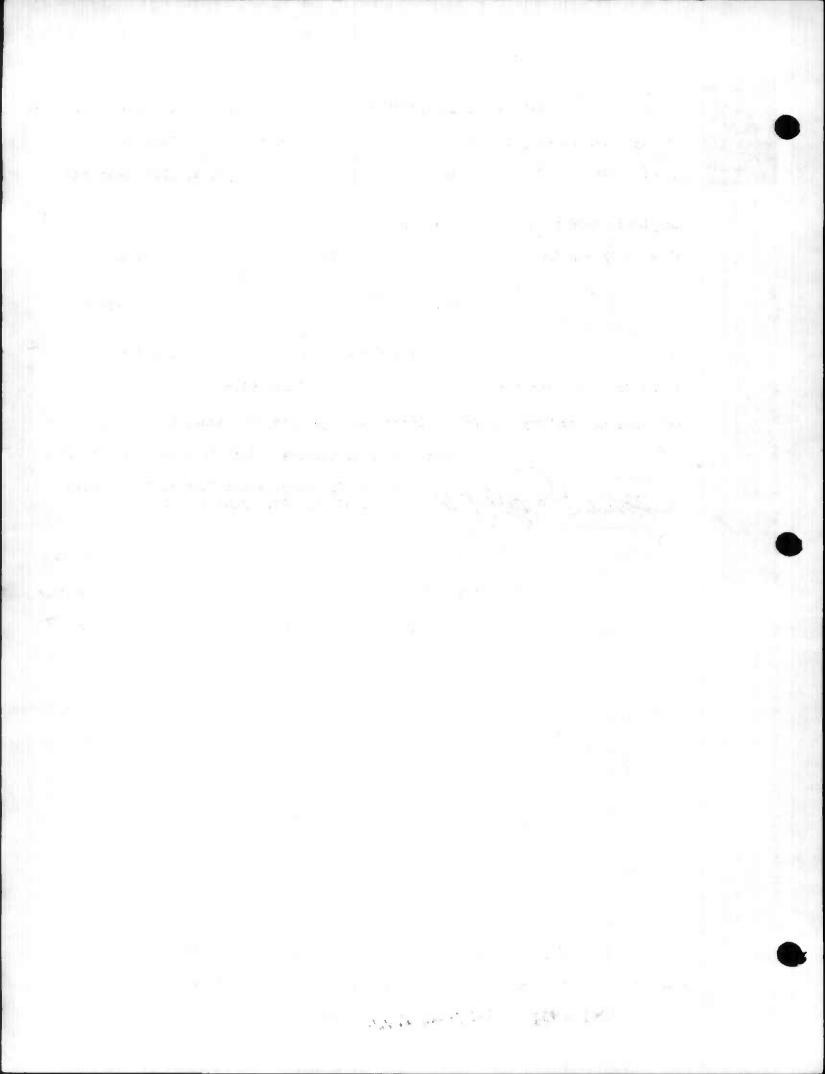
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			30. Nema and edilens of person who co	mpiated cause of d	eeth (Item 23e) (Type, Print)			-		
			Lloyd E. Halvorson		<u>_</u>	Avenue, Fr	ederick,	Maryland	21701		
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month June **Physician** 18, RODGERS, SR. James Harry 11:06 AM /Medical 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frederick Frederick Memorial Hospital Frederick If Under 24 Hrs. 8. Date of Birth Hours Min. July 4, 1932 If Under 1 Year 7. Age (In yrs. last birthdey) 9. Birthplace (Stete or Foreign **Funeral** 110 M 2□ F Months Deys 214-28-7382 65 MaryTand Yrs Director Usuei Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Deperment of Health and Mental Hyglene. Important: If item 27 is merked other than "natural" --- any injury or other traumatic events. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 No Funeral Director 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 13 Consett Place 21702 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No. 1 Yes, Give 152—1972 Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritei Stetus 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Dacedant's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Maintenance Department Hospital 17. Fether's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumeme) Be Elmer Rogers Meyers Carrie 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Betty J. Rodgers, wife 13 Consett Place, Frederick, MD 21702 20e. Method of Disposition

1 □ Buriel 2 □ Cremellon 3 □ Removel from State 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Smithsburg Crematory, June 19, 1998 Smithsburg, MD 4 ☐ Donelion 5 ☐ Other (Specify) 21. Signeture of Funerel Sarvice License 22. Nome end Address of Fecility. Keeney and Basford P.A. Funeral Home MO0255 and c 106 East Church St., Frederick, MD 21701 23a. Pert1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause of aech lina. Approximele Intarvel Between Onsat and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Yr Examiner Physician/Medical Examiner buriel-transit The law requires that the death certificete be executed Sequentielly ilst conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in deeth) Lesl 4 Box 68760. physiciar the Due to (or es e consequence of): deteched for use P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Division of Vital Records, by page 2 should be 24b. Were autopsy findings eveileble prior to completion of ceuse of daeth? Completed 24a. Wes an autopsy this certificate 1 🗆 Yes 1 ☐ Yas 2 ☐ No or Attending Physician: the funeral director. 25. Was case rafarrad to madicel exeminar? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpetient 3 □ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After ! Naturel 2 Accidant 5 Pending 1 Yes 2 No 24 hours effer deeth. investigation 6 Could not be datarmined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end piece, and dua to the ceusa(s) end menner steted. Medical 29a. Cartifier (Check only one) within 2 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number June 19, 1998 D 15804 30. Nama any eddress of person who completed ceusa of daeth (Itam 23a) (Type, Print) Steven A. Pickert MD 180 Thomas Johnson Drive, Frederick, MD 21702 31. Data filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 Registrar

DHMH 16 Rav 6/95

Please Type or Print in Biack indeiible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Year **Physician** JUNE 19, 1998 1:18 pm CHARLES ELVIN RAMSEY JR /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Yeer If Under 24 Hrs. Hours | Min. Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Months Deys 1 DXM 2 □ F 41 214-70-1420 Director May 14 1957 Maryland Usuel Residence of Decedent filed within 72 hours after death with the Marylend 10e Stete 10c. City, Town or Location 10d. Inside City Limits 10h County show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Frederick MD Frederick 1 Yes 2 □ No Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21702 USA Apt.#201 1340 Taney Ave. Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 11. Maritai Stelus ☐Yes 2X No Yes, Give 1 ☐ Never Married 2 ☐ Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white P 3 Widowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Hygiene. restaurant cook 7 is marked other traumatic svant, to 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any light or other traumatic system bacs. Be Edna Wiseman Charles E. Ramsey, Sr 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9306 Granite Circle Frederick, MD 21702 Edna M Cooley mother 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 6/23 Boyds Presbyterian Boyds, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Hilton Funeral Home Barnesville, MD 20838 ter the mode of dying, such as cardiac or respiretory errest, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical Immediate Cause (Finel diseese or condition resulting in deeth) **Examiner** Examiner physician end s the burial-transit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that intitled events resulting in deeth) Lest requires that the death certificate be execu Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) d guipus nse es 23b. Did tobacco use contribute to the cause of death? ed by the e Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed b Š been signated 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed page 2 certificate has 1 ☐ Yes 2 No 1 □ Yes 2 □ No Attending Physician: director, Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manper of Deeth 28e. Dete of tnjury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending Investigation 1 Neturei Injury death. 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital or within 24 hours a To the Funeral D completely filled Medicai 29e. Certifier 1/2 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. (Check only one) 4 29d. Dete signed (Month, Day, Year) 29b. Signaturi 29c. License number nd edd ted cause of death (Item 23a) (Type, Print) 1475

State Registrar 2 3 1838 32. Registrer's Signeture

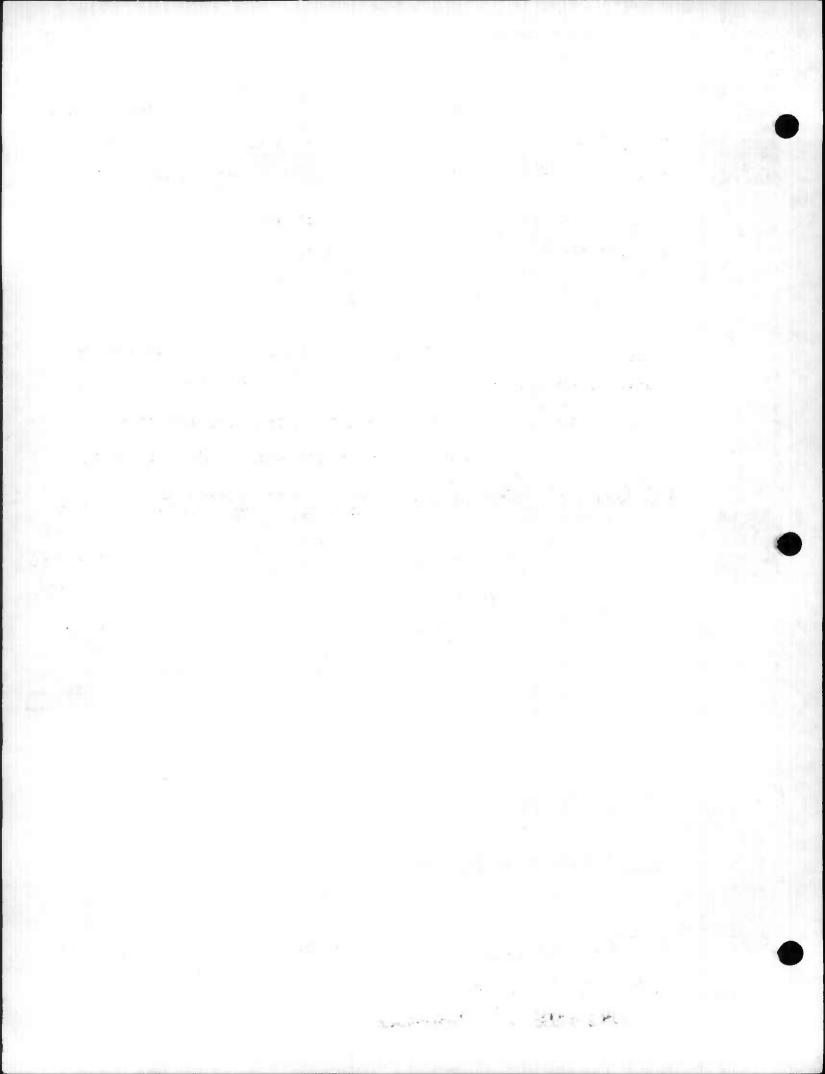


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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month DOROTHY RICE JUNE 22, 1998

Physician /Medical **Examiner Funeral**

02:26 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

76 Yrs. Months Days Hours Min. Jan. 7, 1922 5. Social Security Number 9. Birthplace (State or Foreign 1 M 2 N F 220-34-8551 Maryland Director Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show items 23a or 28a-f shov 1 ☐ Yes 2 🗓 No Director Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6860 Broomes Island Road 20685 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 21215-0020 ò 1 ☐ Yes 2 No Specify: Specify: Black by 3\ Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Foster Parent Social Services Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be Unknown Maggie Jackson 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 s Department of Health an Important: If item 27 is any Injury or other trau once. David E. Rice/Son 6880 Broomes Island Rd. St. Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buriai 2 Cremation 3 Removal from State Brooks UM Church Cem. 6/27/98 4 ☐ Donation 5 ☐ Other (Specify) St. Leonard, MD 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licensee Iladys q. Sevell 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical RIGHT LUNG CANCER

Due to (or as a consequence of): Immediate Cause (Final 1400 disease or condition resulting in death) Examiner LUNG ABSCESS Examiner seeks The law requires that the death certificate be executed burial-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and Box 68760, signed by the ettending physician be detached for use as the burial Physician/Medicai Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did telepicco use contributa to the cause of death? Division of Vital Records, P.O. PULMONARY OBSTRUCTIVE 1 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 Yes ≥ INo 1 Yes 2 No this certificate ai or Attending Physician: The sefter death.

I Director: After this certificate od in by the funerel director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpetient 2 | ER/Outpatient 3 | DOA 2 TO Yes ZO No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mupner of Death 28a. Dete of Injury (Month, Day Year) Certification: 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 ☐ Could not be 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office bullding, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dicompletely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-025519 525 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Dr. Atul Shah, M.D., Prince Frederick, Maryland 20678 31. Dete filed (Month, Dav. Year) 32. Registrar's Signeture State

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Registrar

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	ysician Medical	Chester M. Rect						June	20	1998	1:25 p.m.			
Ex	aminer	4a Facility Name (If not institution,	give street and n	umber)			4b. City, Town, o	or Location of Dea	th 4c. Co	ounty of Death				
		Magnolia Garden				Williams d Va	Lanham			nce Geo				
Fun			3. Sex 1. M 2□ F	7. Age (In yrs.	lest birthday) Yrs.	If Under 1 Ye Months Day		n. (Month, D	irth le <i>y, Year)</i>	9. Birthp	lace (State or Foreign			
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arylan should be ind Mental	0 0	John Sinciali												
Aar 2 sho and and	traumet	19a. informant's Name/Relationshi	p (Type, Print)		19b. Mailin	ng Address (Str.	eet and Number or	Rural Route Numi	ber, City or T	Town, State, Zip	Code)			
	other t	Kathy Vallaster	- Daug											
E/ ma 400	ام م	20a. Method of Disposition 1 X Burial 2 Cremation	3 □Removel from		emetery, crem	sition (Nema of natory or other)	placa)							
Pag ant:	run.	4 Donation 5 Other (Sp.			t Linc	oln Cem	etery	06/23/98 Brentwood, Maryland						
Baltimo pemit. Page: Department of	any In	21. Signatura of Funeral Sarvice Licensea 22. Nama and Address of Facility Gasch's Funeral Home												
m 89 E	2 2	Sanditle O. Darch 4739 Baltimore Avenue, Hyattsville, MD. 2												
Physic /Med · Exami	lical iner	Immediate Ceuse (Finel disease or condition resulting in death)		tastah		(inom					Onsat and Death			
petn:	iel-transit Examiner	Sequentially list conditions	b	Due to (c	or as a conseq	uence of):								
0, = = = = = = = = = = = = = = = = = = =	EX del	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
.O. Box 68760, the deeth certificate be executed y the ettending physician and	the buriel-transit													
riffice ng pl	Med	rooming in doding East												
BOX 6 eeth certific	ar use		d											
the et	sici	Part II. Other significant condition	contributing to	death but not res	ulting in the u	nderlying cause	given in Part i.	23b. Dic	tobacco u	ae contribute t	the cause of death?			
dby the	deteched for use es	Diabetes M	0 11: +us					10	Yes 20	No 3 Pro	bably 4 Unknown			
es that	P	- PLUDELES IN	C/11/103							1				
Of VITAL RECORDS, P Physician: The law requires that this certificate hes been signed b	page 2 should							24a. Wa per	s an autops iormed?	av	ere autopsy findings ailabla prior to			
law r	2 sh							-		of	mpletion of cause death?			
He He	Page							10	Yes 20	No 11	Yes 2□ No			
VITAL HE	director,	25. Was case referred to medical examiner?					26. Place of D	Death (Check only	one)					
Of VITA Physician:		1 Yes 2 No	Hospitai:	Inpatient 2	ER/Outpatien	nt 3 DOA	Other: 4 Nursing	Home 5 Res	sidence 8	Other (Special	(y)			
On Conding Pil	unera On:	27. Manner of Deeth	28a. Date (Mo	e of Injury onth, Dey Year)	28b. Time of Injury	28c. l	njury at Work?	28d. Describe	how injury	occurred				
DIVISION or Attending after death. Director: After	the fu	2 Accident investige				M 1	I Yes 2 No							
OIVISI or Attendate after deat Director:	led in by the funera Certification:	3 Sulcide 6 Could no determine	ed 208. Flac	ce of Injury - At hiding, etc. (Specil	ome, farm, str	eet, factory, offi	Ce	28f. Location City or To	(Street and own, Stete)	Number or Run	al Route Number,			
J sign														
Hospital of 24 hours a Funeral D	completely filled in by the funeral Medical Certification:	(Check only 2 Medical E	xaminer: On the	basis of examina	wledge, death	occurred at the vastigation, in m	e time, date and pla ry opinion, death oc	ice, and due to the courred at the time	e ceuse(s) e , date and p	nd manner as a place, and due t	iteted. o the ceuse(s)			
To the h within 2	Med	one)		nner steted.		7.17.5.11	ense number							
5 5 5	8	29b. Signature and title of certifiar	· lui	ja o	2	1	9550			signed (Month, 2/1/98	Day, roar)			
F	>	Med ag.		10										
(5)	30. Name and eddress of person w George C. H	to completed car	use of death (Item , J / . M	n 23a) (Type, · <i>Q</i> · 4	850 Fo	rbes Bl	lvd. La	nham	, md	20706			
Re	State	31. Date filed (Month, Dey, Year)	00 %	Registrar's Signa	ature .									

DHMH 16 Rev 6/95

Reg. No. 2. Data of Death 3. Time of Death 0215 une 40 County of Death

Funeral Director

deeth with the Meryland show 300 C 30

if hem 27 is marked other than "natural", or hems 23a or 28a-f show or other treumstic event/the Medical Examinar must be notified at permit. Pages 1 and 2 should be filed within 72 hours after to Important: If the 12 is marked other than "natural; or iten any Injury or other reumetic event, the Medical Examinations. TAR

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

the attending physicien and hed for use es the burial-transit certificate be executed Division of Vital Records, P.O. been signed by the s should be detached has funeral director, After Attending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fune

Physician/Medical

þ

Completed

Be

Lo

Certification:

edical

Box 68760.

5. Social Security Number 577-44-0709 Usual Rasidance of Decedant Prince Georges Maryland 10e. Street and Number 11. Marital Status 1 Navar Married 2 Married py 3 ☐ Widowed 4 ☑ Divorced 15. Decedant's Education (Spacify only highast grada complated) Eiamentary/Secondary (0-12) Linsey Robinson 2 19a. Informant's Name/Ralationship (Type, Pnint) 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramovai from Stata 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature - Finaral Sarvice Licensee Examiner

6. Sex

7. Aga (In yrs. last birthday) 64

10c. City, Town or Location

Riverdale

If Under 1 Yaer Months Days

10f. Zip Code

20737

If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year)
Jan 24, 1934

Baltimore Birthpiace (State or Foreign Country) Washington, DC

> 10d. Insida City Limits Yas 2 No

5409 #F1 Riverdale Road

12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specity Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☐XNo Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: Black

Collega (1-4or 5+)

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) Laborer

D.C. Government

Washington, D.C.

16b. Kind of Business/Industry

10g. Citizen of What Country?

United States

17. Fathar's Nama (First, Middia, Last)

18. Mothar's Nama (First, Middla, Maldan Sumama)

Lelia Roberts 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)

Mary S. Robinson /DAughter

20b. Piace of Disposition (Nama of cematary, crematory or other piace)

M859

. End stage renal

5409 #F1 Riverdale Road, Riverdale, Md. 20737 20c. Location - City or Town, Stata Data

Glenwood Cemetery 22. Nama and Addrass of Facility

ALEXANDER S. POPE FUNERAL HOMES

Type 1

2617 Pennsylvania Avenue S.E. DC 20020 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory arrest, shock, or heart tailure. List only one cause on each line.

6/23/98

Immediata Causa (Final disaasa or condition rasulting in daath)

Drabetos

Dua to (or as a consequence of). well to

Hyportension

Dua to (or ss a consequence of) ble cerebro vasenlar accedent

Sequentially list conditions, if any, laading to Immadiata cause. Enter Underlying Causa (Disease or injury that initiated evants rasulting in death) Last

Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed?

24b. Wara sutopsy tindings available prior to completion of cause of deeth?

Approximata Interval Batween Onset and Death

2

2

6months

1 Yas 2 No 26. Pisca of Daath (Check only ona)

1 ☐ Yas 2 ☐ No

25. Was casa ratarred to medical axaminar? 1 Yas 2 No 27. Menner of Death

28a. Data of Injury (Month, Day Year) 5 Panding invastigation

6 Could not be datarmined

Hospital:

1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of

28a. Place of Injury - At homa, tarm, street, tactory, office building, atc. (Specify)

28c. Injury at Work? 1 Yas 2 No

Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28d. Dascribe how Injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29e. Cartiflar (Check only one)

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

1월(Certifying Physician: To the best of my knowledge, death occurred at the time, data and piace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted.

29b. Signatura and titla of certiflar

· chrebita MD

29c. Licansa number D 3497 4 29d. Data signed (Month, Day, Year) 6.17.98

30. Name and eddress of person who compiated cause of deeth (Item 23a) (Type, Print)
CHARL MEHTA, M), 5865, R6BERT OLIVER PL, H121, COLUMBIA, ND 21045.

State Registrar 31. Deta tiled (Month, Day, Year)

32. Registrar's Signetura

what was in the second

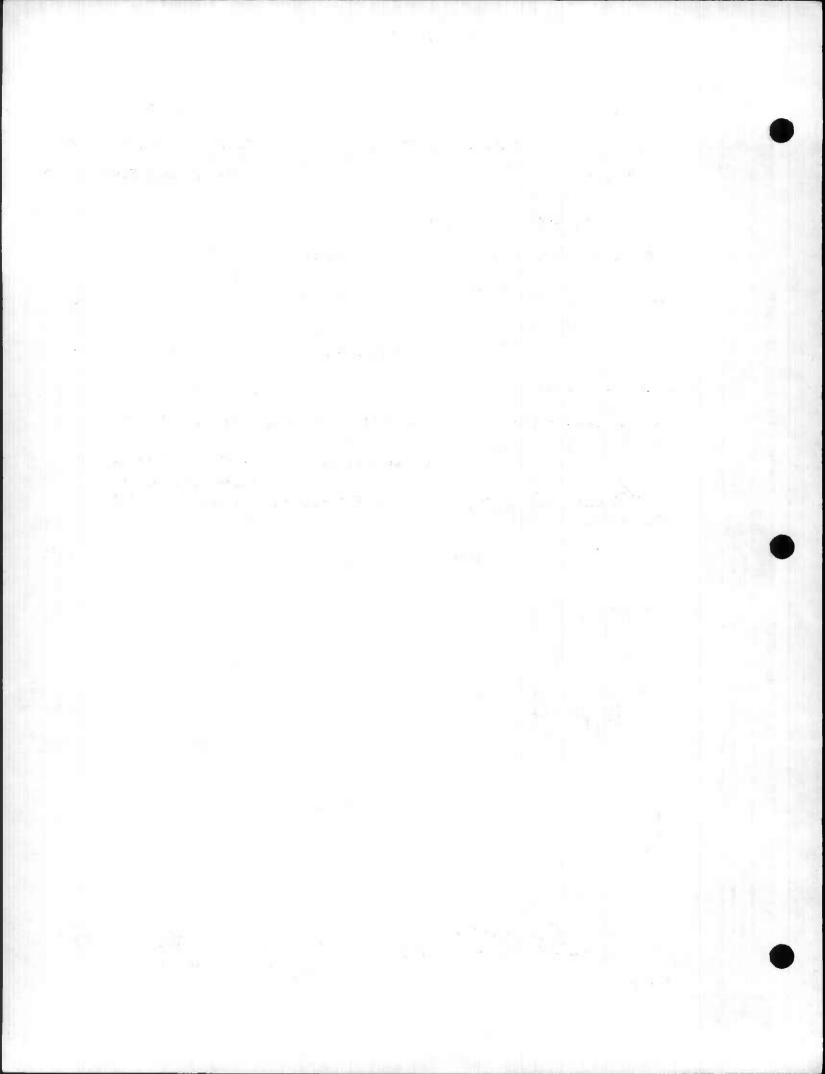
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of	Maryiar		tificate		lealth and r Death	vientai Hy	giene Reg. No.	98	2.1	156				
	Physic /Medi		1. Decedent's Name (First, Middle, L William Bonavent		n					2. Date of De Month June 2	Day	(998 Y	aar 3.	Tima ot Death				
	Exami		4a. Facility Name (If not institution, gi			4b. City, Town, or L	ocation of Deat	th 4c. County of Deeth										
			Sunrise Care Fac.						Elkton					Cecil				
	Funeral Director		182-09-1951	Sax 7. 1⊠ M 2□ F	Aga (In yrs. 92	last birthday) 2 Yrs.	If Under 1 Y	Year Pays	Hours Min. Jan	8. Date of Bir (Month, Da nuary 2,	y, Year)		Country)					
	enyland show	_	Usual Residenca of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation											
	rith the Meryla or 28a-f shor	Director	Maryland Cecil		Ell	kton	1											
	with the	Dir	10e. Street and Number				10f. Zip Co				10g. Citizan of What Country? United States							
	eath w	erai	108 Delaware Ave:	nue 12. Was Daced	21921			nasifu Van ar Na										
020	72 hours efter death with the Meryland natural', or flerns 23a or 28a-1 show dreal Examinat must be notified at	by Funeral	11. Marital Status 1 □ Navar Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Force 1 Yas 2 It Yes, Give Yaar or Date	as? IX No		Yas, specify		lispanic Origin? (Si an, Maxican, Puerto Specify:	Rican, etc.)		Black, White, etc.						
0	72 hours "natural",		15. Decedent's E	ducation		16a. Deced	ent's Usual O)ccup	ation		16b. Ki	ind of Busin	ess/Industr	у				
Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health end Mental Hygiene. Introportant: If item 27 is marked other than "natural", or fer any injury or other traumatic event, the Medical Examines once.	Be Completed	(Specify only highast gi Elementery/Secondary (0-12) 7	Elementery/Secondary (0-12) College (1-4or 5+) owner/manufacturer						Biol								
nd		Be	17. Father's Name (First, Middla, Las	t)					18. Mother's Nem	•								
Z		To	James Roach			1			Mary M.	Herion								
Mar			19a. Intormant's Name/Relationship Warren B. Roach/						end Number or Ru ad, Elkto					1 or Town, Stata				
			20a. Mathod of Disposition		20h F	P.O.B	ox 104	5_	Elkton, A	Maryland	_219	322		Ctoto				
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 [ate	cematary, cran	atory or otha	r pla	09)	June 25			Chester,					
Ħ	artme ortani		4 ☐ Donation 5 ☐ Other (Space 21. Signature of Funeral Servica Lica		R.F	A. Ferr			L 1	1998		nsylvania						
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	-216	-	23a. Part1. Enter the disease, or con	polications that cau	ised the deat							on, Ma						
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											set and Death				
		er			Due to (d	or as a conseq	uence ot):						İ					
oʻ	ficate be executed physician end is the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying	b	Due to (c	or as a conseq	uence of):											
x 68760,		Medical	Cause (Disease or Injury that Initiated events rasulting In death) Last	Due to (o	or as a consequ	uence of):												
Box	death c e ettenc ed for us	ian		d														
P.O.	that the death certified by the ettending detached for use a	Physician/M	Part II. Other significant conditions	ons contributing to death but not resulting in the underlying cause given in Part I.						23b. Dld	tobacco			/				
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<u>e</u>	E ag									10	Yas 2	PNo	1 ☐ Ye	Cecil inthplace (State or Foreign Country) Insylvania 10d. Inside City Limits 1 Yes 2 No Country? Cates narican Indian, nite, etc. White Is/Industry Cical and Cyland 21921 Approximata Interval Between Onset and Death Years. Were autopsy tindings available prior to complation of causa of death? Probably 4 Unknown Were autopsy tindings available prior to complation of causa of death? Probably 1 No Decity) Rural Routa Number, as stated. ue to the cause(s)				
Z.	Physician: The this certificate ral director, pag	Be	25. Wes case referred to medical examiner?	Hospitai:				Oth	28. Plece of Dee									
Division of Vital	ding Phys h. After this funeral di	tlon: To	1 ☐ Yes 2 ☑ No 27. Menner of Death 1 ☑ Netural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date ot (Month,	-	28b. Time of Injury		Injur	4 Mursing H	ome 5 Resi 28d. Describe		-	(Specify)					
Divisi	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director,	Certification:	2 Accident Investigetic 3 Suicide 6 Could not t 4 Homicide determined	28e. Piaca of	Injury - At he, atc. (Spacif	ome, farm, stre				28f. Location (City or To			or Rural Ro	uta Number,				
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	within To the	Me	29b. Signature and title of certifier	0			29c. Li	cens	e number					Year)				
			1	Cedicles	15		1)8	1)23322 6/24/98										
	10		30. Name and address of person who	completed cause	of death (Itam	n 23e) (Type, I	Print)	33	, ELKI	on m	021	1921						
	Sta Registr	_	31. Date tiled (Month, Day, Year) JUN 2 5 1998	32 Reg	Savidson	iture 	2		1									

DHMH 16 Ray 6/95

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				State of Ma	ryiand		riment of ificate o	Health and f Death			8 2	1157		
	Physicia /Medic		Decedent's Name (First, Middle, Last) Frances		Scho	ofs			2. Date of De Month June	Day	Year	3:50 PM		
	Examine Funeral Director	er	SHADY GROVE 5. Social Security Number 060-09-2537	ADVENTI:	(In yrs. la	st birthday)	AL If Under 1 Yes Months Day		TLLE 8. Dale of Bir (Month, De	MON th y, Year)	TGOME	e (State or Foreign		
	9		Usual Residenca of Decedent 10a. State 10b. County		10c. City	, Town or Loca	ation					Inside City Limits		
	ser death with the Maryland Herrs 23s or 28s-1 show Inst. must be notified at	tot	FL Broward		Maı	gate						1 ☐ Yes 2 → No		
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Country	?		
	m 23s must	eral	1050 Country Club 11. Maritel Status	Drive 2. Was Decedent E	ver in 119	13 W		063 f Hispanic Orloin? (5	Specify Ves or No	USA 14. Baci	e - American	Indian		
020	urs after Nr. or its Examine	by Funeral	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2XXX If Yes, Give Yeer or Detes:			Yes, specify Co	f Hispanic Origin? (5 uben, Mexican, Puer lo Specify:	to Rican, etc.)	Black, While, etc. Specify: White				
Maryland 21215-0020	within 72 ho ans. than "natur to Medical J	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired)					16b. Kind of Bu							
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Mar	and and a man		19a. Informent's Neme/Relationship (Type Joel C. Schofs - S					et end Number or R			Stete, Zip Co 7836	ode)		
	Health Health Mem 27 other tr		20a. Method of Disposition	5011	20b. Pla	ace of Disposi	ition (Name of	Village,	Date	20c. Location -		, State		
mo	Pages sent of rit: If its rry or o		1 Buriat 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State			Cemete		6/7/98	Roche:	lle Pa	rk, NJ		
Baltimore,	permit. Departri Importa any infu		21. Signature of Funerel Service Licensee 22. Name and Address of Facility Louis Suburban Chapel 13-01 Broadway, Fairlawn, NJ 07410											
	Physician		234. Pan I. Enter the disease, or complice thock, or need failure. List only on	ations thet caused cause on each line	lhe death	. Do not enter	the mode of o	lying, such es cardia	c or respiratory a		A	oproximate tervel Between nsel and Death		
	/Medical Examiner		tmmediate Cause (Finat disease or condition resulting in death)			es e consequ	-				1	ninutes		
	D .E	ner	- h		300 10 (01	00 0 0010040	61100 017.							
60,	cata be executed physician and the bunal-transit	Sequentially list conditions, if any, teading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 1 Pert tt. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to 1 Yes 2 No 3 Prob												
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	death certifi e attending ed for use as	sicial	Pert tt. Other algnificant conditions cont	given in Pert I.	23b. Did	tobacco usa co	ntributa to th	ne cause of death?						
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Vital Record		Completed	,		-				24e. Was perfe	an autopsy ormed?	availa	autopsy findings able prior to delion of cause ath?		
E E	The is	Co							10	Yes 2 No	1 🗆 Y	'es 2□ No		
 	3 5	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	ospitel:	i che	-D/O	2004	Other:	ath (Check only		or (Consital			
on of	After fune	⊢ -	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	1 ☐ Inpetier 28e. Date of Injun (Month, Day	y	ER/Outpatient 28b. Time of Injury		njury at Vork?	Home 5 ☐ Resi 28d. Describe	how injury occur				
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A complataly filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28f. Location (City or To	Street and Numb wn, State)	er or Rural F	loute Number,							
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	with Void	Σ	29b. Signature and this or critical	a	2	Mo	29c. Lice	9 46 7 41		JUNe				
			30. Name and address of person who cor Deepak Sachdeva, N					Medical C	rentist 1- enter Dri uryland	tospital ve				
	Stat Registra		31. Dete filed (Month, Day, Yeer)	32. Registra		dson-Ran		Ţ						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6:58 Kathryn Sm: th 1998 3 1 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL None BALTIMORE CITY 8. Date of Birth (Month, Day, Year) August 7, 1924 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□ M 2\ F Yrs. 73 203-20-1917 Pennsylvania **Director** Usual Residence of Decedent Peges 1 end 2 should be filled within 72 hours after deeth with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23e or 28e-f show 10a. State 10c. City, Town or Location 10d. inside City Limits 10b. County r than "natural", or items 23a or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Pennsylvania Directo Union Union Township 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America R.R. 1, Box 106 17889 Funeral 14. Race - American Indian, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever In U.S. Armed Forces? 11. Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Simon Hess Esther Heider 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul J. Smith/ Husband RR1, Box 106, Winfield, Pennsylvania other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) June 4, 6 1 X Burial 2 Cremation 3 Removal from State Selinsgrove, permit. Pege Department of Important: If eny Injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) Shreiners Cemetery 1998 Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Seebold Funeral Home assers 601 North High Street, Selinsgrove, PA 17870 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner Pancreation mass buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) physician s the buriel Physician/Medical Due to (or as a consequence of) 80 950 0 signed by the a Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4, 2 Unknown 1 ☐ Yee 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? page 2 s 1□ Yes 2 No 1 ☐ Yes 2 No certificate director, 25. Was case reterred to medical 86 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 € No Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Naturel 5 Pending injury 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide

State Registrar

Medicai

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

29b. Sign and title of certifier

Robert Med. Ilians, Tower 110, 600 N. Wolfe St. 32. Registrar's Signature

30 Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

JUN 1 0 1998

M.D

Pulia Davidson-Randall

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

MO 21287

29d. Date signed (Month, Day, Year)

altimore, Maryland 21215-0020

requires that the death certificate be executed

Records, P.O. Box 68760.

Division of Vital

Hospital or Attending Physician:

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24 hours after death.

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completely

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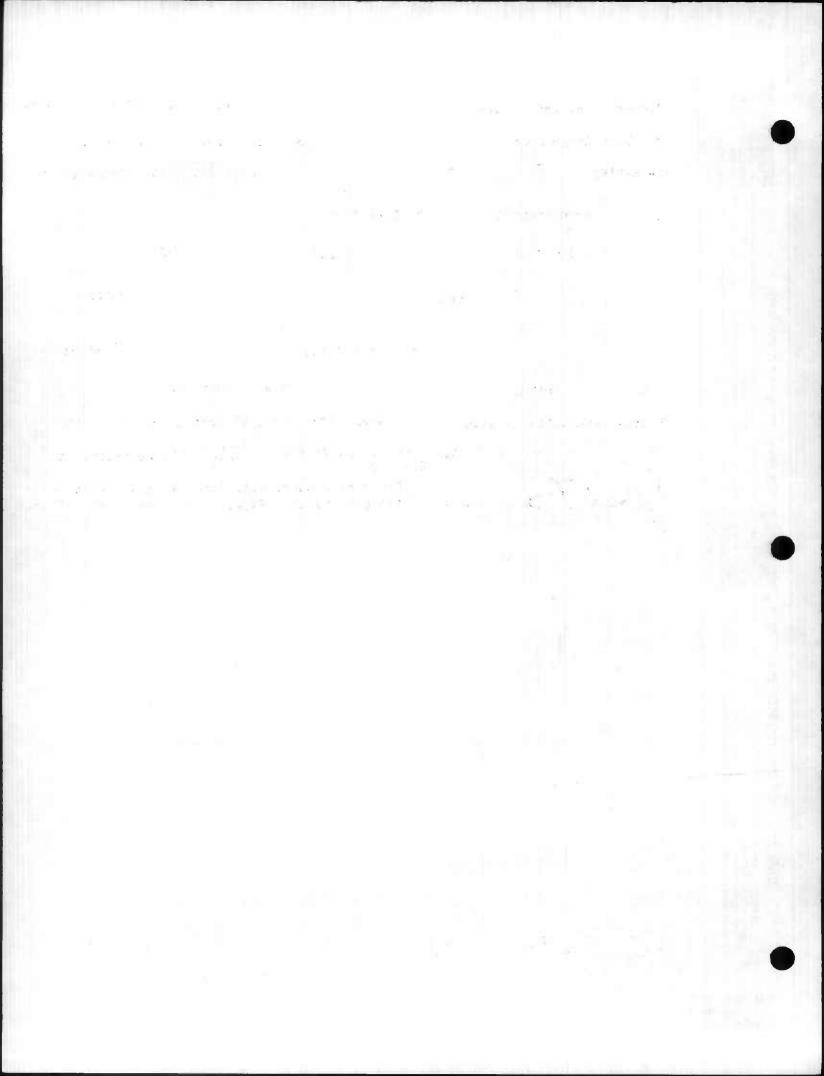
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 31 1998 6:00 p.m. Alfred George Suller /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 223 Rock Ridge Road Millersville Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 12XM 2□ F Days 042-38-6191 52 Sept 27, 1945 Director Connecticut Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Modical Examiner must be notified at Anne Arundel Millersville 1 ☐ Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 223 Rock Ridge Road USA 21108 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours after 1 X Yes 2 No 1 Never Married 2X Married aftimore, Maryland 21215-0020 rr ves, Give Year or Dates: 1968-70 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiana. College (1-4or 5+) Elementary/Secondery (0-12) Digital Equip. Computer Sales . Pages 1 and 2 should be filled w frinent of Haaith and Mental Hygian lant: if Item 27 is marked other th Jury or other traumatic event, In-18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Susan Mankulics Peter Suller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 223 Rock Ridge Road, Millersville, MD Ann Suller - wife Regina 21108 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetery or other place)
r Lady of the Fields June 4 1 Surial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or pncs. Millersville, MD 5 Other (Specify) 1998 Cemetery
22. Name and Address of Facility 21. Signature of Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD.

Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Applications to the cause on each line. 21146 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel 1983 disease or condition resulting in death) Examiner Examiner physician and the burial-transit certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 88 usa 23b. Did tobacco use contribute to the cause of death? been signed by the s should be datached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 has 1 Yes 2 HA 1 ☐ Yes 2 ☐ No cartificata Division of Vital Hospital or Attending Physician: funeral director. Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Ves 2 No Certification: To this 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Affar To the Hospital or Attending within 24 hours after death.
To the Funeral Director; Afte completely filled in by the fun 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of continue MI 036242 6/3/98 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Eugene Thomas Manion, M.D. 8028 Ritchie Hury Suite 110-112, Pasadera, Maryland 21122 8028 Ritchie Hwy Suite 110-112 32. Registrar's Signature 31. Date filed (Month, Day, Year) State wha Davidson-Randall JUN 0 9 1998 Registrar

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 9 8

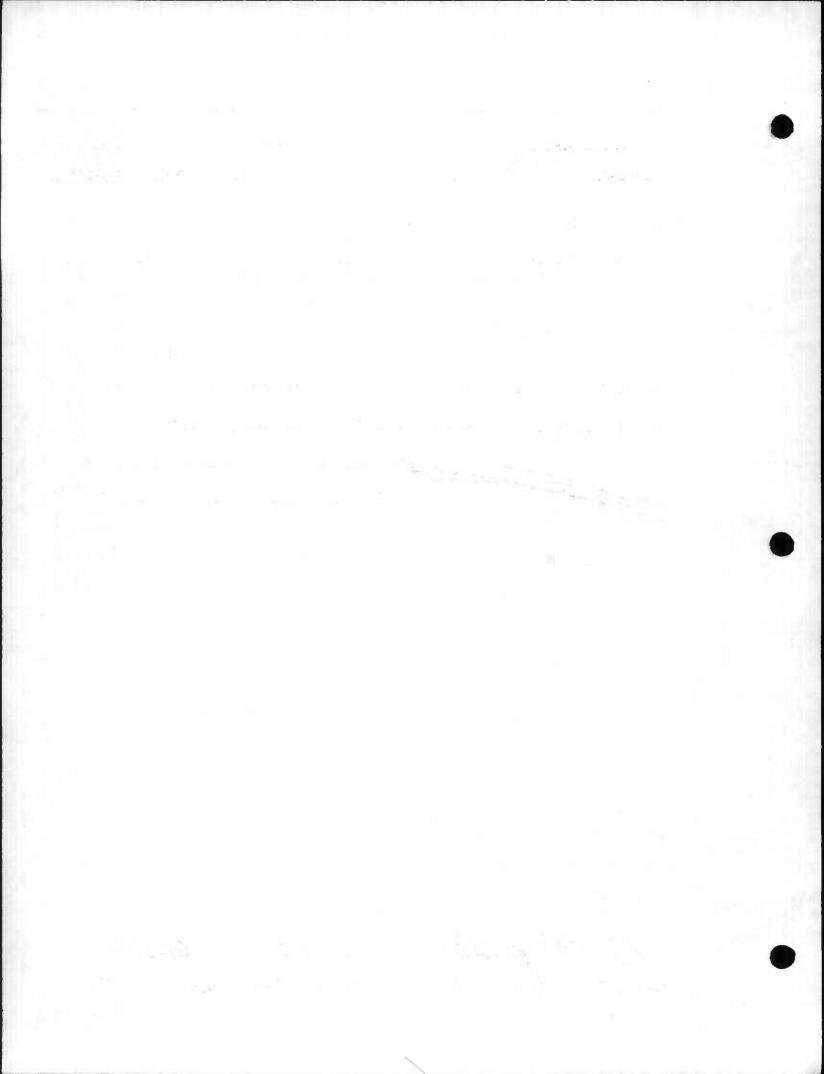
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	Funerai Director		5. Social Security Number 6. 341-10-3412	8. Date of Birth (Month, Day, Mar. 2	Date of Birth (Month, Day, Year) ar. 26 1909 Illinois							
	puel Ma		Usual Residenca of Decedent 10a. State 10b. County		10c. City, Tow	vn or Location				_	10d.	Inside City Limits
	Mary	to	NM Bernal	i110	Albu	querque						OX Yes 2 □ No
	or 28e	Director	10e. Street and Number		11100	10f. ZIp			10	Og. Citizen of	Whet Country?	
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020	hours after death with the Maryland ural', or items 23s or 28s-f show all Example must be notified as	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				Hispanic Orlgin? (Span, Mexican, Puerto Description Specify:	pecify Yes or No- o Rican, etc.)	14. Rac	ck, White, atc.	
21215-0020	d within 72 hours piene. r then "neturel", the Medical Ex	Completed	15. Decadent's Elementery/Secondery (0-12)	ducation ade completed) College (1-4or 5+)			rk done se retin	e during most of wor ed)	king		usiness/Indust	
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Ž	nd 2		Rilla M. Spell	,								
Baltimore,	8 4 4 0		20a. Method of Disposition 1 Burial 2 Cramation 3 E 4 Donetion 5 Other (Speci	Removal from State	cemete	ny, crematory or c	thar pl	ematory	Date 2	20c. Location -	City or Town,	State
Balt	permit. Page Department of important: If any injury or spce.		21. Signature of Funeral Service Lice	- /		22. Name an	d Addr	ress of Facility	Homo			110.
			23a. Part 1. Enter the disease, or com shock, or heert fallure. List only	plications that caused the	ne death. Do	not enter the mod	e of dy	ring, such as cardiac	or respiretory arre	Id . 2	0838 App	proximate erval Between
	Physician /Medicai Examiner		Immediate Ceuse (Final disaasa or condition rasulting in death)	a gar)grer	re.	les	27 Poot	+		On On	isat and Death
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		ysic	Pert II. Other significent conditions of	contributing to death but	not resulting l	n the underlying o	ause g	iven in Part I.	23b. Dld to	bacco use co	ntribute to the	cause of death?
0	thet the de ad by the deteched								1 □ Ye	2 No	3 Probabi	y 4 Unknown
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}	Physician: r this certific real director,	ToE	axaminar? 1 ☐ Yes 2 ☐ ¥0	Hospital:	2□ ER/0ι	utpetient 3 DC	A O	ther: 4 Nursing H	oma 5 Heside	nce 6 Oth	ner (Specify)	
0	ding Ph h. After th funeral		27. Menner of Death 1 Matural 5 Pending	28a. Date of Injury (Month, Dey Y	(ear) 28b.	Time of 2	8c. Inju	ury at ork?	28d. Describe ho	w injury occur	red	
Division of	leat tor: the	Certification:	2 Accident invastigatio 3 Suicide 6 Could not be determined	n e	- At home, fa	М	1[]Yes 2□No	28f. Location (Str. City or Town		per or Rural Ro	outa Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completaly filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying Ph	yalcian: To the best of r niner: On the basis of e and menner state	caminetion en	e, death occurred ad/or investigation	at the t	ime, date and place, opinion, death occur	, and due to the ca rred et the time, de	use(s) and ma te and place,	anner as stated and due to the	1. cause(s)
	within To th comp	M	29b. Signature and title of certifier			290	. Lican	sa number	29	d. Date signe	d (Month, Day,	, Year)
			トンナ	1)1	1		2	0148		611:	7/98	-
			30. Name and eddress of person who	completed cause of dea	th (Item 33a)	(Type, Print)				- 1	1	
			Steven H. Doli	nsky, MD	#4 E	xecutiv	re.	Park Ct.	German	ntown,	Md.	20874
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Yaar JUNE 25, 1998 MAE SHRINER 10:00pm ELLEN /Medical 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 118 WATER STREET THURMONT FREDERICK If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Months Days Hours Min Yrs. Director 213-24-8843 OCT. 6, 1918 MARYLAND Usual Rasidance of Decedent the Maryland 10a State 10h County 10c, City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □XYes 2 □ No Director MARYLAND FREDERICK THURMONT 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? death with USA 118 WATER STREET 21788 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer or Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any injury or other traumetic event, the Medical Exercises. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: ð Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry completed Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS CLOTHING FACTORY 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) VIOLA BLANCHE FRANKLIN G. REIFSNIDER SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) MAURICE E. SHRINER (HUSBAND) 118 WATER ST., THURMONT, MD 21788 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cramation 3 ☐ Removal from State 6/29/98 THURMONT, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) BLUE RIDGE CEMETERY 21. Signature of Funeral Service Lifensen -22. Nama and Addrass of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788 Approximate Interval Between Onsat and Death 23a Bart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. **Physician** Several /Medical Immediate Cause (Final mos disease or condition resulting in death) Examiner leass ician and buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last physician t s the buriel-Coronary Box 68760. arte Physician/Medical Dua to (or s a consequence of) ettending 980 ed by the e Part II. Other significant conditions contributing to death but not rasuiting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. iabetes Mellitus 1 | Yes 2 No 3 | Probably 4 | Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen has 1 Yes 2 No 1 Yas 2 No Division of Vital Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certific. 25. Was case reterrad to medical examiner? 26. Place of Death (Check only ope) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manne of Death 28b. Time ot 28d. Dascribe how injury occurred Certification: 28c. injury at Work? 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be determined 3 Sulcide Place of Injury - At homa, tarm, street, factory, office building, etc. (Specify) 28t. Location (Streat and Number or Rural Route Number, City or Town, State) filled in by 4 Homlcide 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, date and piace, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examinar: On the basia of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) and mannar stated. To the To the To the F 29b. Signature and title of certif 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of parson who completed cause ot death (Item 23a) (Type, Print) J. COUPER, THURMONT, MD. 21788 m.D. BRAD 52 WATER ST. 32. Registrar's Signature 31. Date tlied (Month, Day, Year) State This Akwilson Raylett JUN 2 9 Registrar



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State of Maryland / Department of Health and Mental Hygiene

4318 Buckeystown Pike 12. Wes Decedant Evar In U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-fif Yes, Specify Cuban, Mexican, Puarto Rican, atc.) 14. Was 12. Was Decedent of Mexican Puarto Rican, atc. 14. Was 12. Was Decedent of Mex	Day 25, 1998 7:30 pm 4c. County of Death Frederick
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Karkyn Rham

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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 98

		1. Decedent's Name	a (First Middle 1	25/1		Ce	ıınıcat	e or	Death		2. Date of D	Reg. No.			3. Time of Death	
Physic			M. SHE								Month	Dey		Year		
/Medi Examii		4a. Facility Name (#			n <i>ber)</i>				4b. City, Tov	vn, or L	June			of Death	11:16 AM	
LAGIIII	161	Doctors (Communit	y Hospit	al				Lanh	am					orge's	
Funeral	П	5. Social Security No	umber 6.	Sex	7. Age (In yrs.	last birthday	If Under Months	1 Year Days	If Under 2	4 Hrs. Min.	8. Date of Bi				ace (State or Foreign	
Director		217-44-	4103	1□M 2 []F	86	Yrs.		,-			3/17	/12		Wash	.,D.C.	
land		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or L	ocation							10	d. Inside City Limits	
the Marylar 28a-f show	tor	Md.	P.G.		La	andove	er								Yes 2□No	
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items items	Funeral	11. Marital Status		Armed Fo		,S. 13.	Was Deced If Yes, spec	dent of F cify Cub	lispenic Orig an, Mexican,	in? (Sp Puerto	ecity Yes or N Rican, etc.)	0- 1		- America k, White, e		
be filed within 72 hours after deeth with the Maryland ial Hygiene. d other than "natural", or items 23a or 28a-f show ent, it a Mac cal Exami ar rout be notified a vent, it a Mac cal Exami ar rout be notified.	by F	1 Never Merrie	_	1 ☐ Yes If Yes, Giv Year or D	e		1 □ Yes	2 🔀 No	Specify:				Specify:	B1	ack	
z should be nied within 72 hours end Mental Hygieral is marked other than "natural", aumatic event, the Med cal Exa			15. Decedent's E	ducation	ates:	18a. Dece	dent's Usua	al Occur	pation			16b. Kir	nd of Bu	d of Business/Industry		
2 2	Completed	(Speci	ify only highest gr	ade completed) College (1	-4or 5+)	(Give	kind of wor DO NOT us	rk done se retire	pation during most d)	of work	ring				,	
or the	Con	12th		Conogo (.		D:	ietar	y P	Aid			D.(C. (Gove	rnment	
d de la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Lasi	1)					18. Mother	r's Nam	ne (First, Middle, Maiden Surname)					
Health and Mental Hygiene. tem 27 is marked other than "nature other traumatic event, in a Medical	Lo		n Lewis			1				Ma	argaret Griffith rel Route Number, City or Town, State, Zin Code, 70					
n 27 is n		19a. Informant's Na			/D=	19b. Maili	ng Address				t Rd. # 101, Greenbelt,					
Health tem 27 other tr		Thomasin		orbert	20b. I	Place of Disp	osition (Nan	ne of		ert	Date			reen City or Tov		
at: If he			Cremation 3 [State	cemetery, cre				/25	/00					
Department of Health Important: If item 27 any Injury or other tr once.			A Donation 5 Other (Specify) Resurrection Cem. 6/25/98 Clinton, Md. Signature of Funeral Servica Licensee 22. Name and Address of Facility H. C. Washington S. Cong. Co., The State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State													
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		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.									or respiratory	N.E.	200	19:	Approximate	
hysician		SHOCK, OF Hear	t lallure. List only												Interval Between Onset and Death	
Medicai kaminer		Immediate Cause (F disease or condition		. AH	reso	Sch	not	Tic	7-1-6	200	nt D	180	des		Hour	
arriller	16	resulting in death)		-	Due to (d	or as a conse	quence of):		1		nt D port	1			0 4	
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ig physicien and as the burial-transit	Ехаг	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or I	nditions, mediate	1.1	Due to (or as a conse	quence of):	_ 1	1	1.	lescu	1.	1	100		
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as the	800	resulting In death) L	.ast		500.00		4001100 017.								•	
ettendin for use	Physician/N			d	_									1		
ate has been signed by the ettendin page 2 should be detached for use	/sic	Part II. Other signific	cant conditions	contributing to de	ath but not res	ulting In the u	inderlying c	ause giv	ven in Pert I.		23b. Did	tobacco	uae con	tribute to	the cause of death?	
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s certific director,	To B	examiner?		Hospital:	npatient 2	ER/Outpatie	nt 3 DC	Oth	or:		me 5 Res		Othe	r (Specify)	
ordeath. ector: After this certifically the funeral director.	nc.	27. Magner of Death	5 Pending		of Injury h, Day Year)	28b. Time o		8c. Injur			28d. Describe					
or: Al	Certification:	2 Accident	investigatio	n	, , , , , ,		М		Yes 2□N	10						
linect in by	THE STREET	3 ☐ Suicide 4 ☐ Homlcide	6 Could not be determined	286. Place	of Injury - At h ng, etc. <i>(Specil</i>	ome, farm, st	reet, factory	, office			28f. Location City or To	(Street and wn, State)	d Numbe	er or Rural	Route Number,	
eral C	Ce	202 Cortifica	Land	untales T ii												
ithin 24 hours after death. o the Funeral Director: Att omplately filled in by the fur	edical	29a. Certifier (Check only one)	2 Madical Exam	miner: On the ba	sls of examina	wiedge, deat tion and/or in	n occurred a vestigation,	at the tir , In my o	ne, date and pinlon, deat	place, h occur	and due to the red at the time	cause(s) date and	and mai place, a	nner as sta and due to	ited. the cause(s)	
thin	N N	(Check only 2 Madical Examiner: On the basis of examination and/or investigation. In my opinion, death occurred at the										at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)				

State Registrar

DHMH 16 Rav 6/95

drittlerof certifier

29c. License number

29d. Date signed (Month, Day, Year)

10 POR 14300 GAUANT FOX UANE, SUITE 222 BOWLE MD 20715

29d. Date signed (Month, Day, Year)

10 POR 14300 GAUANT FOX UANE, SUITE 222 BOWLE MD 20715

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Physician		тет	L		SCOTT	JR		JUNE	10, Dey 1998	Year }	01:50 AM	
/Medica Examine	4e Facility Nem	ne (If not instituti	on, give street end no	umber)			4b. City, Town, or				an an a	
	5. Social Securi	VOLTA A	6. Sex	7. Age (In yrs. les	et hiethday)	ff Under 1 Year	BRENTWOO			CE GEC		
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or 28a-fa	MD	F	PG	BRE	NTWOOD)					1 Yes 2 □ No	
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or use			d									
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2 2									en eutopsy omed?		re autopsy findings ileble prior to	
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Director:	3 Sulcide	de dete	mined 200, 10100	a of Injury - At hom ding, etc. (Specify)	e, farm, stree	t, fectory, office		City or To	Street and Numb	per or Rurel	Poute Number,	
		1 Cante	log Physician: To th	a host of my keeping	TT Itz	ONE and the ti	me date and also	3700	VO Ta	- Who		
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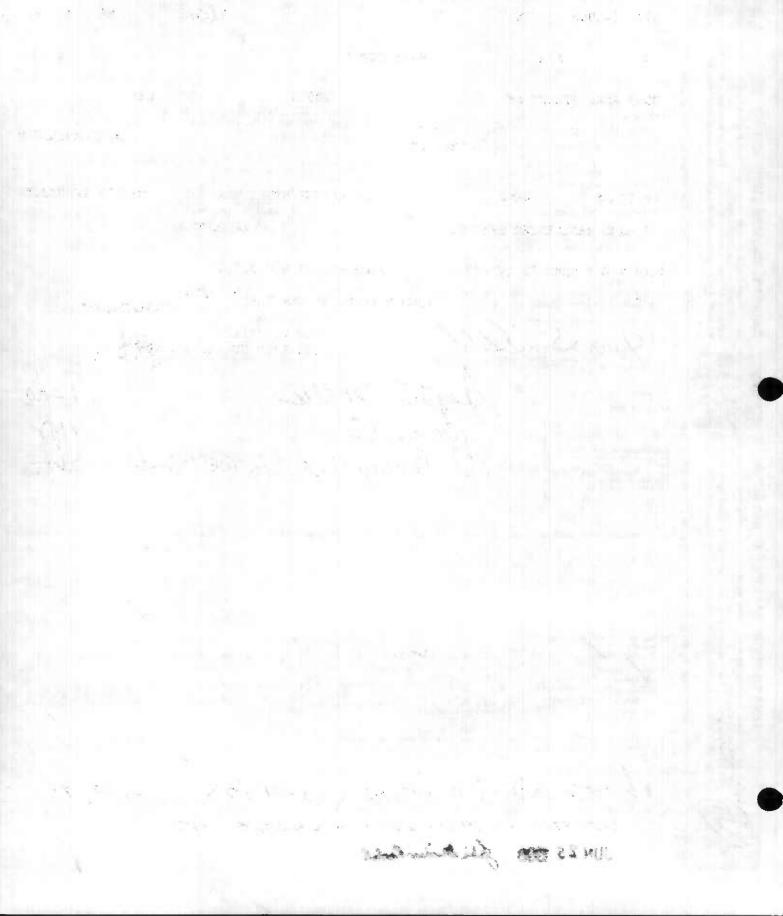
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		State of Maryland	I / Department of Certificate or			iene	5	1166
Physician	Decedent's Nama (First, Middle WALLACE)	e, Last) HENRY	SHAMLE		2. Data of Dear Month 6/20/9	th Day	Year	3. Time of Death 9:34p.m.
/Medical Examiner	4a Facility Name (If not institution		O/MILLIO	4b. City, Town, or		4c. County	of Death	•
Examine	SOUTHERN MARYI	AND HOSPITAL		CLINTON		PG		
Funeral Director	5. Social Security Number 577–24–5066	6. Sex 1 M 2 F 7. Age (In yrs. la	Yrs. If Under 1 Yea Months Day		8. Date of Birth (Month, Day 2/15/20	Year)	Coun	place (State or Foreign http:// HINGTON, D
me 23a or 28a-f show must be notified at neral Director	Usual Residence of Decadent 10a. State 10b. County DC N		Town or Location ASHINGTON	747			1	0d. Inside City Limits
or 28a-f	10e. Street and Number		10f. Zip Code)	- 1	0g. Citizen of V	Vhat Coun	ntry?
23a o	3969 AMES STRE	EET NE	20	019		USA		
or he	11. Marital Stetus 1 Never Married 2 Mari 3 Widowed 4 Divorcad	If Vac Give	If Yes, specify Cu		pecify Yes or No- o Rican, etc.)	Blac	k, White,	en indian, etc. -AMERICAN
natur	15. Decaden (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5+)	16a. Decedent's Usual Occ (Giva kind of work don life, DO NOT use reti	supation ne during most of worred)	rking	16b. Kind of Bu	siness/inc	dustry
or than the man	12 YEARS	NONE	TILE SETT	ER/STORE	MANAGER	PRIV	ATE 1	INDUSRTY
Mental Hyginarked other atic event, To Be Co	17. Father's Name (First, Middle, RICHARD McALL)				A DOUGLA		a)	
permit. Togges i end a should be med begen and place and important: If Item 27 is marked other any injury or other treumatic event, page.	19a. Informant's Name/Relations KATE McCOY SHAI 20a. Method of Disposition 1 Durial 2 Cremation 4 Donation 5 Other (S	MLEY (WIFE) 3 □ Removal from State car LING	aca of Disposition (Name of metery, cramatory or other p COLN MEMORIAL 22. Name and Add	OA, B, C, D, viace) CEMETERY dress of Fecility OHN T. RHI	E,&F 6/30/98 NES	20c. Location -	City or To	own, Stata
nysician (Medical xaminer	23a. F. 1. Enter the disease, or or heart failure. List immediate Cause (Final disease or condition resulting in death)	complications that caused the death. only one cause on each line.	Do not enter the mode of d	lying, such as cardia	or respiratory arr	åst, 20017		Approximate Interval Between Onset and Death
ettending physician end for use es the buriel-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Causa (Disease or Injury that initiated events resulting in death) Last	c. Pld Due to (or a	es a consequence of): Prehmo - Va as a consequence of):	culon	aleia	ent		217
by the ette eched for hysicia	Part ii. Other significant condition	ons contributing to death but not resul	ting in the underlying cause	given In Part I.	23b. Dld to	1/		o the cause of death? bably 4 Unknow
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certificate h rector, page	25. Wes case referred to medica	1		00 01	1 U Y		11	Yes 2 No
this aidi	examiner? 1 Yes 2 No 27. Manyler of Death	Hospital: 1 Inpatient 2 128a. Date of Injury	28b. Time of 28c. In	Other: 4 Nursing H	ath <i>(Check only</i> of dome 5 Resid 28d. Describe h	enca 6 🗆 Oth		(y)
within 24 hours after deeth. To the Funeral Director: After toompletely filled in by the funeral Medical Certification:	1 Maturai 5 Pendir 2 Accident investi 3 Suicide 6 Could 4 Homicide determ	gation not be	M 1 me, farm, street, factory, office	☐ Yes 2 ☐ No	28f. Location (S City or Tow		er or Rure	al Route Number,
within 24 hours after deet To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier Certifyir (Check only one) 2 Medical	ng Physician: To the best of my know Examiner: On the basis of examination	riedge, death occurred at the on and/or investigation, in my	time, date end pleca y opinion, death occu	a, end due to the curred at the time, o	ause(s) and ma date and placa,	anner as s	stated. o the cause(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year ELWOOD BURNEY SPROUSE JUNE 27, 1998 4:45 PM /Medical 4e. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL ST. MARY'S If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) **X**□M 2□ F Days 66 Yrs. FEBRUARY 20, 1932 232-40-2693 OHIO Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND PRINCE GEORGE'S BRANDYWINE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 16800 BALD EAGLE SCHOOL ROAD 20613 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1953-59 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2/2/No Specify: ò Specify: WHITE 30 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) **FURNITURE** Elementary/Secondery (0-12) College (1-4or 5+) TRUCK DRIVER MOVING 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JAMES LEE SPROUSE LOLA WILMA BAILEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLOTTE M. BISHOP 16800 BALD EAGLE SCHOOL RD., BRANDYWINE, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 D 5 Other (Specify) THE HUNTT CREMATORY JUNE 29, 1998 WALDORF, MD 22. Name and Address of Facili THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX BROHAWN M00053 σ. 156, WALDORF, MARYLAND 20604-0156 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown by Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 20 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Place of Deeth (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 | Yes 2 | № 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end mariner as stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) JUNE 29, 1998

Examiner The law requires that the death certificete be executed Box 68760 P.O. Records, Division of Vital

physician ar 88 for use as signed by peen page 2 certificate Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director; To the Hospital of within 24 hours or To the Funeral Completely filled

Funeral

Director

Herns 23e or 28a-f show ther naut be notified at

the Maryland

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Physician /Medical

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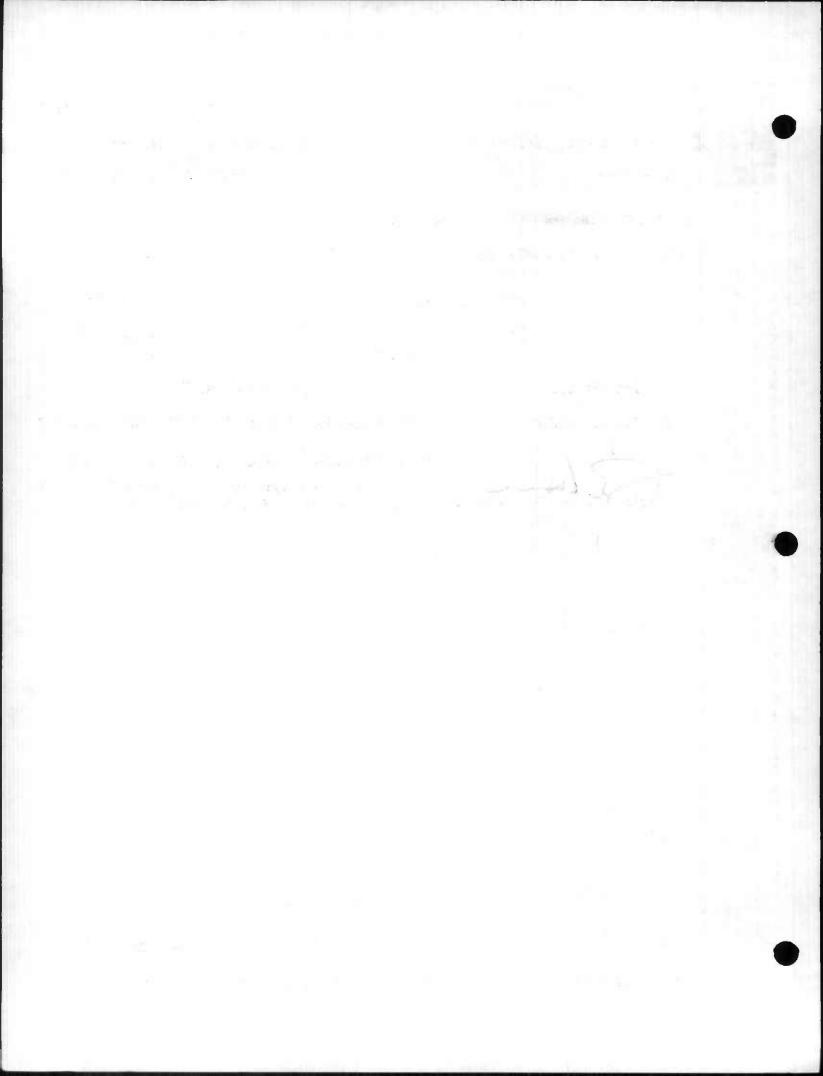
altimore, Maryland 21215-0020

State Registrar

31. Dete filed (Month, Day, Year) JUN 3 0 1998

R. TIMOTHY PACE, MD, 700 OLD LINE CTR. #202, WALDORF, MARYLAND 32. Begistrer's Signature This Devolear Real B

30. Name and eddres of person who completed cause of deeth (Item 23a) (Type, Print)



Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JUNE **Physician** 1998 3:35 PM SYLVESTER GRAHAM WILLIAM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL | Houser 1 Year | Hours | Min. | S. Date of Birth (Month, Day Year) | Hours | Min. | April 26,1911 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Yrs. MICHIGAN 369-09-2883 Director Usuel Residence of Decedent with the Manyland permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumstic event, the Medical Exercited must be notified. 10a. State 10b. Count 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Directo MARYLAND **CHARLES** WALDORF 10e Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2660 UPBROOK COURT 20602 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

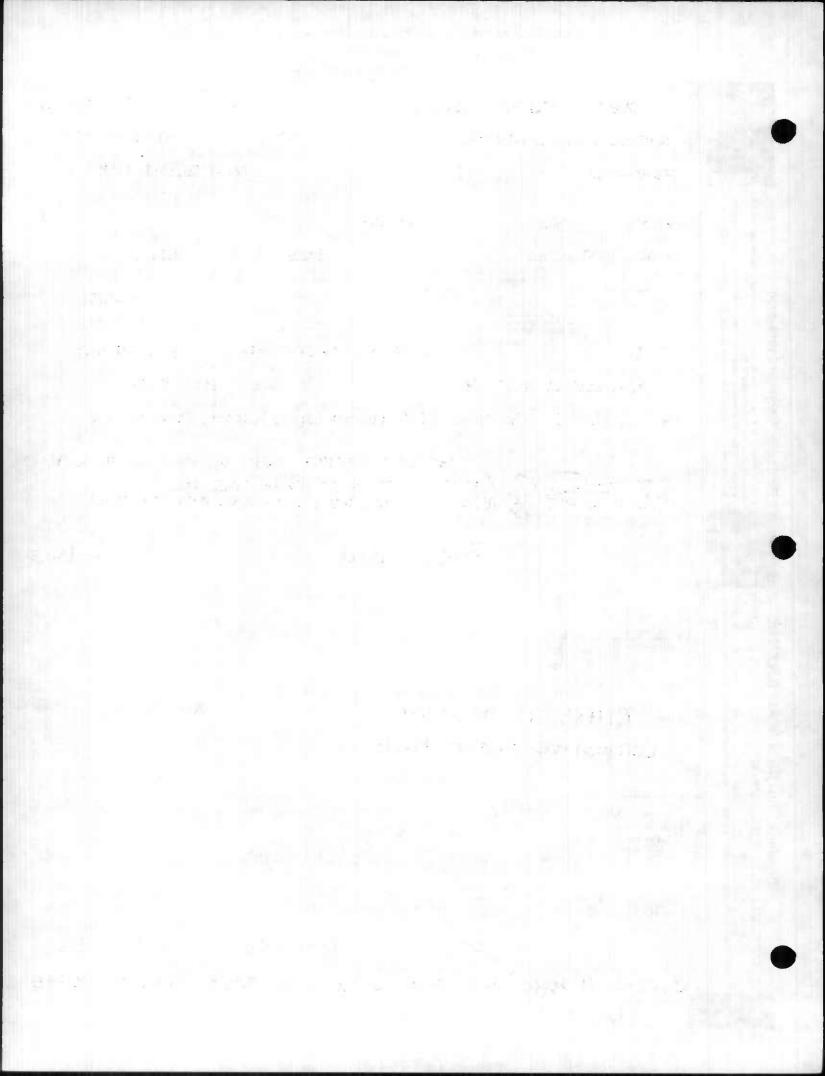
1 (2) Yes 2 | No 1942 - If Yes, Give
Year or Dates: 1945 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: WHITE Aq 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) Cotlege (1-4or 5+) WASHER & DRYER REPAIRMAN SELF EMPLOYED 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) HENRY CLINTON SYLVESTER MAUD FBLYN YOUNG 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) KAREN E. STANDRIDGE/DAUGHTER 2660 Upbrook Court, Waldorf, Maryland 20602 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete
4 ☐ Donetion 5 ☐ Other (Specify) THE HUNTT CREMATORY JUNE 24,1998 WALDORF, MARYLAND 22. Name end Address of Facility
THE HUNTT FUNERAL HOME, INC. 21. Signature of Funeral Service Licens DAVID A. GOFF MO1095 P.O. BOX 156, WALDORF, MARYLAND

23a. P.int. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20604 **Physician** /Medical Immediate Cause (Final rneumonia diseese or condition resulting in death) **Examiner** Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician end the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting In deeth) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part It. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. signed by the e 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CIHRROSIS OF LIVER by 24b. Were eutopsy findings evallable prior to completion of cause of deeth? Congestive Heart Failure 24a. Was an autopsy performed? Completed peen certificate has t 1 Yes 2 No 1 TVes 2 No director, Hospital or Attending Physician: Be 25. Wes cese referred to medicel examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 finpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Yes 2 No Certification: To funeral 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28a. Dete of Injury (Month, Dev Year) After 1. Netural 5 Pending Investigation within 24 hours after deeth.
To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) end menner es stated edical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date and ptece, end due to the ceuse(s) end menner stated. the the 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifie 29c. License number 30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print) Patel M.D. 7501 Surratts Rd #367 Clinton mo 20735 Suresh A. 31. Dete filed (Month, Day, Year) 32. Registrar's Signature

John Davidson Restell

State Registrar

JUN 3 0 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Month Venny Judith Saenz 2342 HFS JUNE 71 1998 /Medical 4a. Fecllity Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** HOSPITAL UNION ELKTON CECIL If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 23F Deys 14 Yrs. 286-74-5729 Director FEB. 18, 1984 BOGOTA, COLOMBIA Usual Residence of Decedent 10e Stete 10h County 10c. City, Town or Location 10d. Inside City Limits ns 23e or 28a-f sh must be notified 1 Xyes 2 No FAIRFIELD Director GREENWICH the 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 57 BYRAM TERRACE DRIVE 06830 U.S. A. Funeral Nems ? 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Marital Status trsumatic event, the Madical Examiner filed within 72 hours after 1 Never Merried 2 ☐ Married 1 X Yes 2 No Specify: COLOMBIAN 21215-0020 ö Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: HISPANIC "natural". 15. Decedent's Education 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest gred completed) Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) other t Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 should be finent of Health end Mental I int: if item 27 is marked of SAENZ HUMBERTO ELSA KAPHAEL INES VIVAS 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) MOTHER SI BYRAW TERRACE DR., GREENWICH, CT 06830 ELSA INES VIVAS other 1 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 6 1 Burial 2 ☐ Cremation 3 Removel from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) ST. JOHN'S CEMETERY 7-1-98 DARIEN, CT. 21 Signature of Funeral Service Licenses 22. Name and Address of Facility SPICER - MULLIKIN FUNERAL HOME HARVEY C. SMITH, JR. 1000 N. DUPONT HIGHWAY, NEW CASTLE, DE 19720 23e. Parti. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physiclan** need and chest towns /Medical Immediate Cause (Final disease or condition resulting in deeth) **Examiner** Due to (or es e consequence of) The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequença of): P.O. Box 68760. Physician/Medicai the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? yd bengis 1 Yes 22 No 3 Probably 4 Unknown MOTOR VEHICLE ACCIDENT of Vital Records. by 8 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? WITH FIECTION certificate 1 Yes 20KN0 1 Tyes 2 No. Attending Physician: 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 1XYes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this in by the funeral 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) Division After 5 Pending Investigation 1 Neturel Z335 PM death. 1 Yes 2 No MOTOR VEHICLE ACCIDENT efter death JUNE 21, 1998 2 Accident 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide ŏ CECIL COUNTY NB MILE MALKEK INTERSTATE To the Hospital within 24 hours of To the Funeral Completely filled Hospital Medical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner es steted. Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 0926 39 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) UNION HOSPITAL - ELKTON A. SHAWN CAPNEVALE 31. Dete filed (Month, Day, Year) JUN 3-0 1998 32. Registrer's Signeture State Fulia Davidson Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death D Schuler 2329 James 24, 1998 June 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Ikton Union eci If Undar 1 Yaar | If Under 24 Hrs. | 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. lest birthday) 23 Yrs. 8. Data of Birth (Month, Pey, 12 3 Birthpiaca (Steta or Foreign Country) VICRINICA Days Hours Min. 18 M 2□ F 215-28-5926 Irainia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits xford 1 ☐ Yas 2 No hester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19363 1025 hrome Toad USA 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Naver Married 2 Married 1 Yes 2 No Spacity. specify: White 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementery/Secondary (0-12) College (1-4or 5+) Assemblyman 17. Father's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Surneme) lary Ellen Granbel 19a. Informant's Neme/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Schule Vona 1025 Chrome Road Oxtord 20b. Placa of Disposition (Neme of cemetery, cremetory or other) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State Oxford, 4 ☐ Donation 5 ☐ Other (Specify) xtora 21. Signatura of Funerai Service Licensee 22. Name and Addrass of Facility Oxford, PA Funeral Hone 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death tmmediate Cause (Final acute remul disease or condition resulting In death) heert taule Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or as e consequenca of) Preumonia Due to (or as a consequence of): ASCUD 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No

Physician /Medicai **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6

permit. Peges 1 end 2 should be filed within 72 hours after death w Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a to any Injury or other traumatic event, the Medical Experiment page.

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

Schuler, James

the Medical Examiner nust be notified at

Director

by

Completed

Be

director.

attending physician and for use as the bunal-transit The law requires that the death certificeta be axecuted signed by the ai cate has been signated; page 2 should b After this certificate death.

within 24 hours aftar deal To the Funeral Director: completaly the

Physician/Medical Examiner þ Completed Be

Certification: To

State Registrar

29b. Signature and title of certifier

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medicat 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 ☐ Yes 2 ☐ No 27. Manner of Deeth 28e. Date of tnjury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stele) 28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homleide 15d Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examtner: On the bests of examinetion end/or threstigetion, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) end manner stated. Medicai 29a, Certifier (Check only one)

Jui Chih Han MD

29c. License number

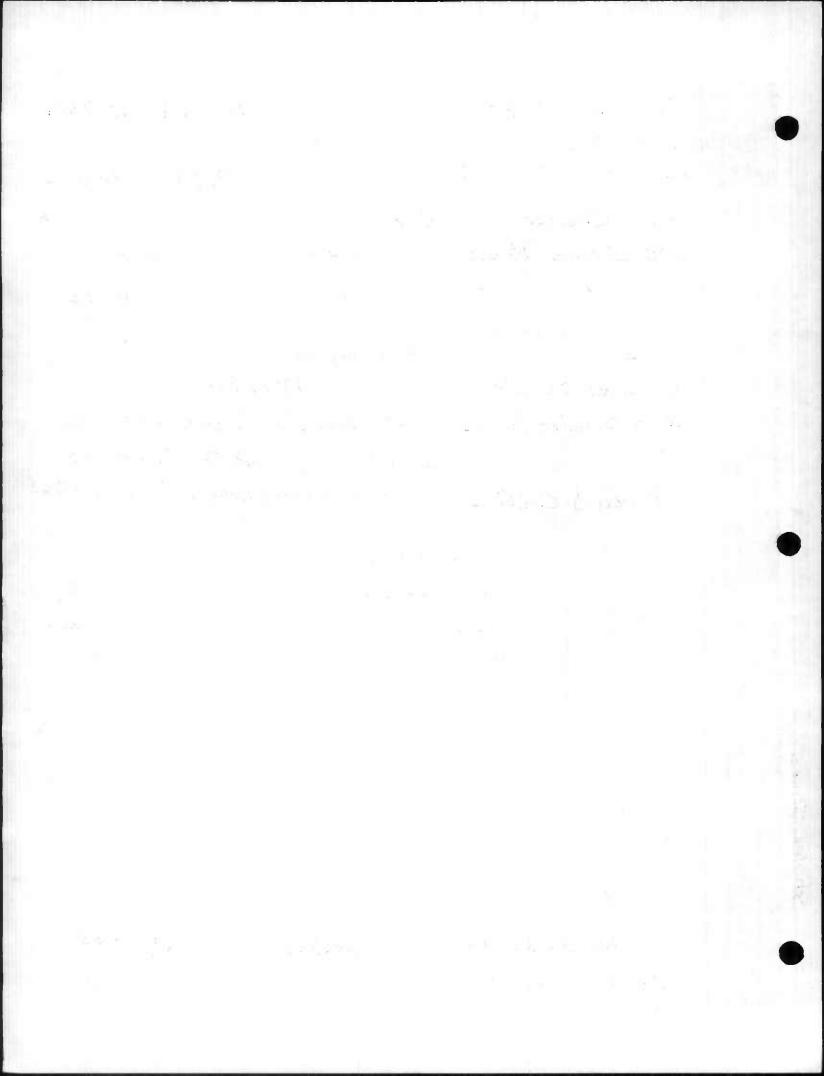
29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Chih HSU , MD West main st. JUI

32. Registrar's Signeture

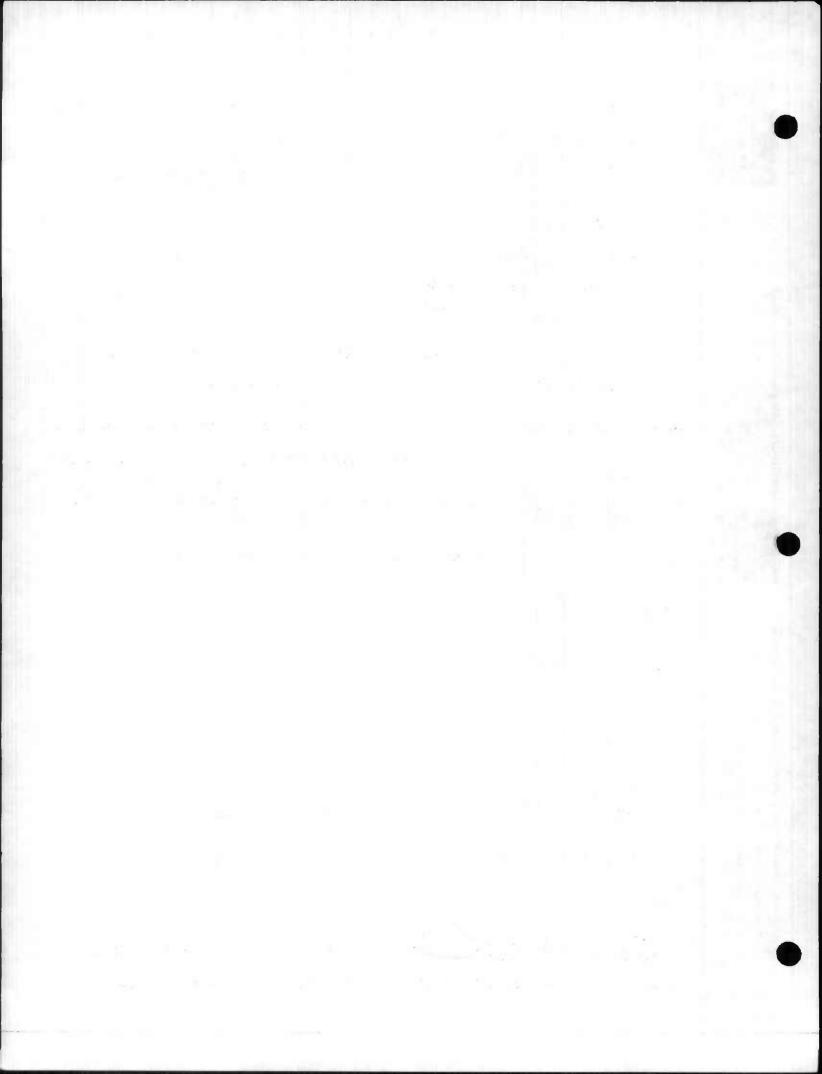
31. Date filed (Month, Dey, Yeer) JUN 26 1998 Julia Vavidson



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State of Maryland / Department of Health and Mental Hygiene 98 2117

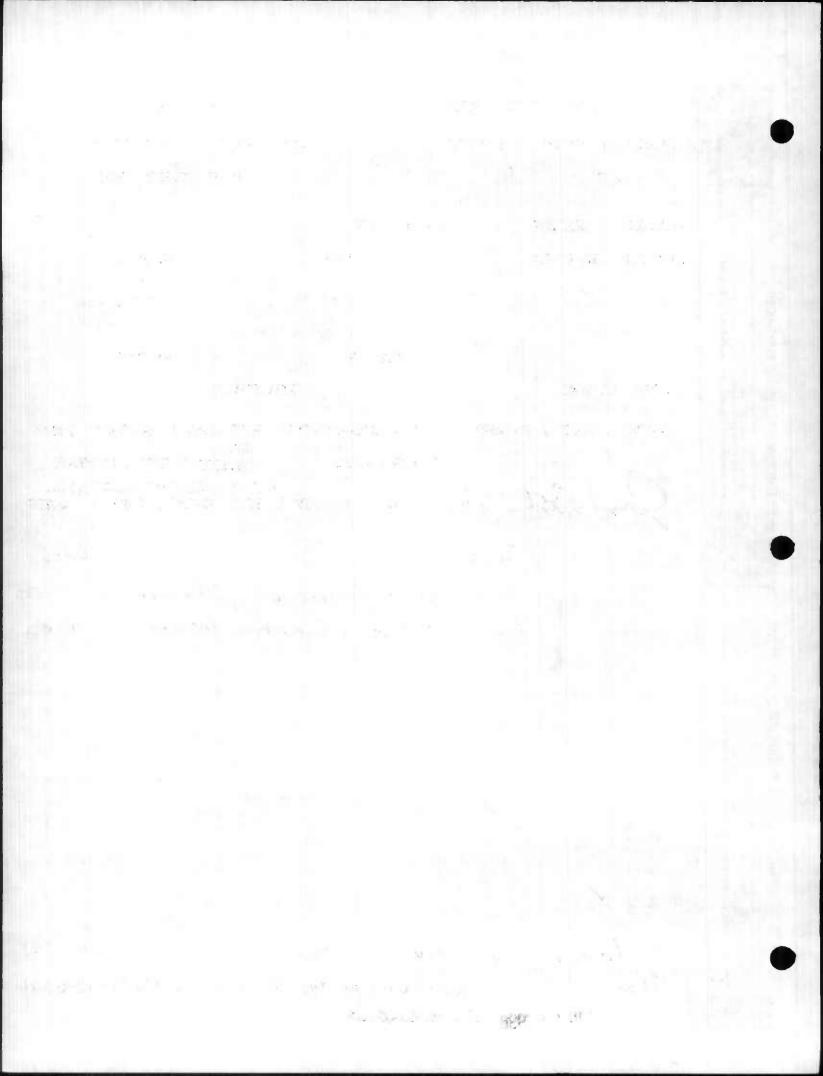
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D 1 1 1		20e. Method of Disposition		20b. Place of	Disposition (/ ry, crematory of	vame of		Date	20c. Location		
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To th To th	Me	29b. Signature and little of certifier	man.	/		29c. Licen	se number	2	29d. Date signe	d (Month, Di	ay, Year)
		Much	11/1/2	who	>	D 3	1551		JUNE 8	. 1998	3
		30. Neme and address of person who	completed acuse of de	ath (Item 23a) (Type, Print)	2 3			501111 0	, 1//	
		RUSSELL R. DeLUCA	-MD 1600 S	. CRAIN	HWY.,	SUITE	602 GI	LEN BURN	IE, MARY	LAND 2	21061
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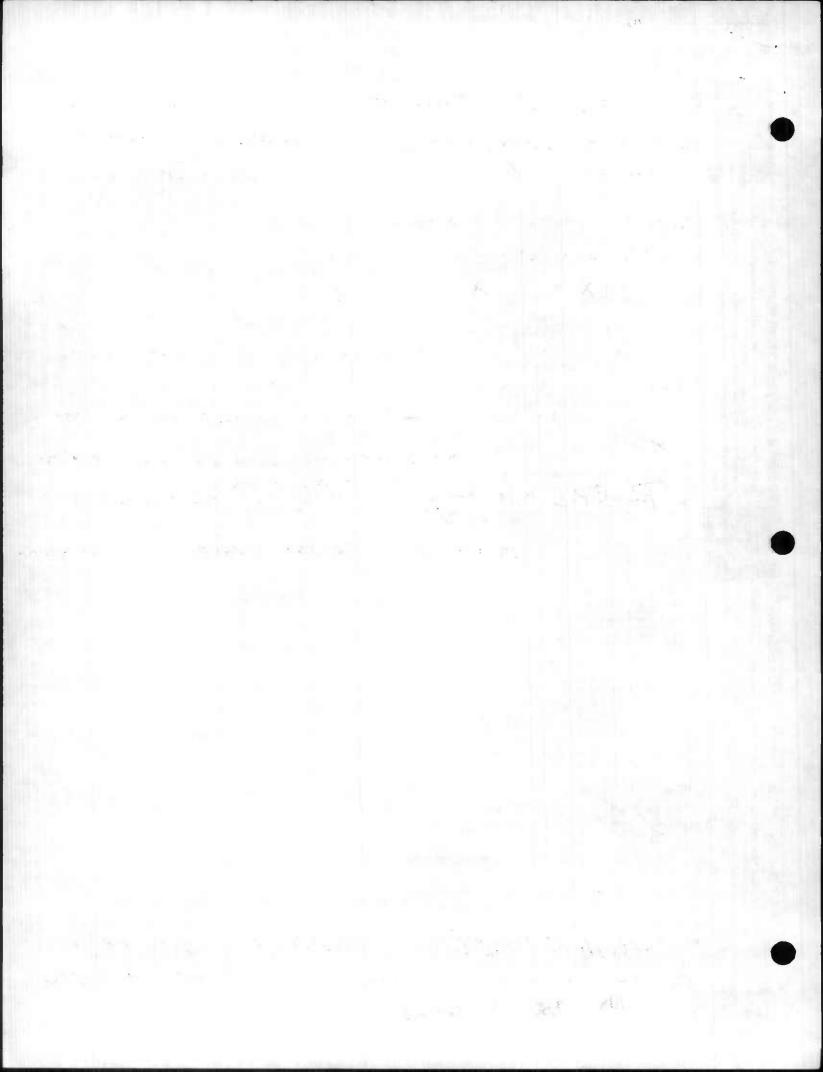
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State of Maryland / Department of Health and Mental Hygiene 98 21172

					Ce	rtificate	of I	Death			Reg. No.			1116
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Funeral		5. Sociel Security Number 6. Se	ex 7. Age	e (In yrs. last l	birthday)	If Under 1		If Under 2		8. Date of Bir (Month, De	th Vees)	2110		ece (Stete or Foreign ry)
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· ·		Usuei Residence of Decedent									,			
show		10e. Stete 10b. County		10c. City, To	wn or Lo	ocation							10	d. Inside City Limits
e Me	cto	MARYLAND CALVET	TS	HUN	TING	TOWN -								1 ☐ Yes 2 ☐ No
e 22	Director	10e. Street and Number				10f. Zip C	ode				10g. Citiz	en of V	Vhet Count	ry?
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 07:50 AM TEASLE) THELMA LEVONIA JUNE /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner 井103 DALLAS PLACE TEMPLE If Under 24 Hrs HILLS 4537 PRINCE GEORGES If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth 214-32-9802 Months Deys Hours Min. 1 M 200F Vrs 18,1929 Statham, **Director** Usuel Residence of Decedent with the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show solical Examiner must be notified at 1 Yes 2 □ No Md. lemple Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 453 26748 @37, WU STATES permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a eny Injury or other treumatic event, the Marical Examiner manal page. Funeral 14. Race - American Indian, Bleck, White, etc. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus I ☐ Yes 2 ♠No If Yes, Give Year or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 No BlACK Specify. by 35-Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Heme 2 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Cox IGNE JOHNSON 2 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 👊 🏋 19e. Informent's Neme/Reletionship (Type, Print) 453 A1145 Tample Itills Md Arol IEARLE 20b. Pleca of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition Dete 1 Suriel 2 Cremetion 3 Removel from Stete -27-9h Aurel Wastienal 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fuperal Service Lices 22. Name end Address of Fecility Aura 6001 combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, any one cause on each line. 23a. Pert1. Enter In shock, or head Approximete Intervel Between Physician Immediate Ceuse (Finel disease or condition resulting In deeth) /Medical CARDIOVASCULAR DISEASE · ARTERIOSCLEROTIC Examiner Due to (or es e consequence of): Physician/Medical Examiner The lew requires that the death certificate be executed physician end the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequenca of) attending pl for use as t Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS p 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24e. Was en eutopsy has t irector, page 1□ Yes 2 No 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? Certification: 1 Neturel 2 Accident 5 Pending investigation 1 Tyes 2 □ No ector: A 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide id filled in I Hospital 24 hours edicai 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) and menner as stated. Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date and pleca, and due to the cause(s) and manner stated (Check only one) within 2 To the 29d. Dete signed (Month, Day, Year) 29c. License number

(5)

State Registrar

JUN 26 1998

MARIO F G 31. Dete filed (Month, Day, Year)

30. Name and eddress of person who completed chuse of deeth (Item/29e) (Type, Print)

GOLLE

JR MB, 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785
32. Registrer's Signatura

Jalia Mexicles Rachell.

JUNE 22, 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Decedent's Name (Eirst, Middle, Last)
 DEVEN
 DEVEN 2. Dete of Deeth **Physician** 3:02 AM JUNE /Medical 4e. Facility Neme (If not institution, give street and number)

Doctor S Hospital 4b. City, Town, or Location of Deeth Lanaham 4c. County of Deeth Prince Georges Examiner If Under 1 Year 5. Sociel Security Number 239–18–3093 If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign **Funeral** Deys Hours 1 □ M 2 KF North Carolina 75 Director Usuel Residence of Decedent 10a State 10d. Inside City Limits 28a-f show Prince George's Capital Heights, traumetic evant, the Medical Examiner must be notified at 1 Yes 2 No by Funeral Director 10e. Street end Number 408 Possum Court 10f. Zip Code 20743 10g. Citizen of What Country? 6 items 23a USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 ☐ Married "naturel", or 1 ☐ Yes 2 X No Specify: Specify.Black 3 ₩Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Covernment Postal Worker nd Mental Hygiene. marked other than Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any liquy or other traumatic event, 90c8. 17. Fether's Neme (First, Middle, Last)
Willie Preston 18. Mother's Name (First, Middle, Melden Surname) Be Eva Penn 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 6619 7th Street NW; Washington, D.C. 20012 19a. Informent's Neme/Relationship (Type, Print) Barbara Harper Daughter 20e. Method of Disposition 20b. Place of Disposition (Neme of 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State cheltaniam National Cenetery 6/24/98 Cheltanham, Mil 5 Other (Specify) 22. Name end Address of Fecility Bianchi Funeral Service 21. Signature of Funeral Service Licensee c/o 814 Upshur St. NW Washington, D.C. 20011 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiec or respiratory errest, shock, or hear feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medicai Immediete Ceuse (Final diseese or condition resulting in death) **Examiner** Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): pue Box 68760. ettending physician Physician/Medical P.O. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? s been signed by the should be detech 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? hes this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) No No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation 1 Yes 2 No offer deeth Director: A d in by the f deeth 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled Medicai 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) and manner as stated.

Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, dete and placa, and due to the cause(s) end menner stated. Signeture no title of certifier 29h 29c. License number 29d. Dete signed (Month, Day, Year) of deeth (Item 23a) (Type, Print) am and address of person who completed cause 715 Belle Point DR. Greenbett Md. Kobi 31. Date filed (Month, Day, Year) State JUN 23 1998 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** 23 June 8:15 PM PAULINE W. **TAYLOR** /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's College Park 8000-51st Avenue Months Days Hours Min. August 23, 1914 Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. lest birthdey) **Funeral** 1 □ M 2 🖾 F 83 579-32-9085 Director Virginia Usual Rasidance of Decedent the Maryland 10c. City. Town or Location 10a. Stete 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 X Yes 2 No Maryland Prince George's College Park Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code should be filed within 72 hours after death with and Mentel Hygiene.
marked other than "natural", or tems 23a or? 8000-51st Avenue 20740 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11 Marital Status Was Decedant Ever in U,S. Armed Forces? Black, Whita, etc. 1 ☐ Yes 2 🐼 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 Widowed 4 □ Divorced Year or Dates Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Librarian Government 12th permit. Pages 1 end 2 should be file Department of Heelith end Mentel Hy Important: If Item 27 is marked orbh any Injury or other traumatic avant PRES. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Sampson Woodson Azora Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Richard T. Taylor/Brother-In-Law 6536 Princess Garden Parkway, Lanham, MD 20706 20b. Place of Disposition (Neme of Cemetery cremetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burlal 2 ☐ Cremation 3 ☐ Removel from State Maryland National Memorial Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart feilure. List only one cause on each line. Bowmo Approximate Interval Between Onset and Death **Physician** Acute myocardial Infanction /Medical tmmediate Cause (Final disaase or condition rasulting in death) Examiner Examiner physician end the bunal-transit thet the death certificete be executed Sequentially list conditions, if any, laading to immediata ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consaquanca of) as for usa as ed by the detached Part It. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributs to the cause of death? flyperchilsterolemon 1 Yes 2 No 3 Probably 4 Wiknown bengis d be det p law requires non Onswon dependent diabete mellitis 24b. Were autopsy findings available prior to completion of ceuse ot death? 24e. Was an autopsy Completed peeu paga 2 hes The 1 ☐ Yes 2 ☐ No 1 Yes 2 N this certificate or Attending Physician: director, Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Homa 5 🛱 Rasidence 6 ☐ Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how Injury occurred After Certification: 1 Matural 5 Pending investigation 1 Yes 2 No ithin 24 hours after death.

the Funeral Director: Alport Suppletely filled in by the fu death. 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 3 Suicida 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only one)

Division of Vital Records, Hospital

29b. Signature and title of certifier

050600

29c. License number

29d. Date signed (Month, Day, Year)

30. Narce and address of person who completed ceuse of death (Item 23a) (Type, Print)

GreenBelt SILVIA SHIH MT) 7243 B Hanorer pakwang 31. Date filed (Month, Dey, Year)
JUN 2 5. 1998

State Registrar 32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 🌖 🤉 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth JMMe 25 Dey 199 8 ar **Physician** 9:00A Dorothy Lee Trapani /Medical 4e. Fecliity Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Civista Medical Center La Plata Charles 7. Age (In yrs. last birthdey) if Under 1 Year if Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Sociel Security Number Birthplece (Stete or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Yrs. Director 212-20-1906 Usual Residence of Decedent March 18,1925 Illinois 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at Yes 2 No Directo Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Funeral #4 Circle Ave. 20640

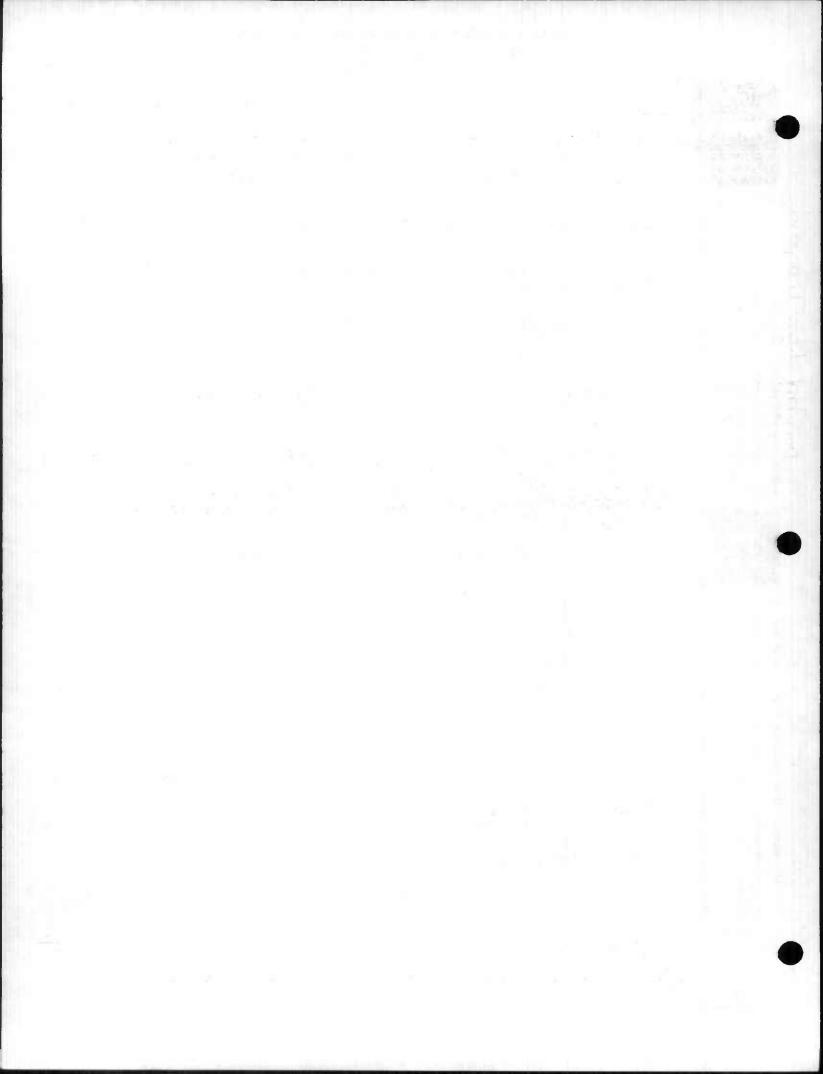
13. Was Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Ricen, etc.) S.A. 14. Race - American Indian, 12. Was Decedent Ever In U,S. 11. Marital Status h and Mental Hygiene.
7 is marked other than "natural", or them traumatte event, the Medical Examiner. Armed Forces? Black, White, etc. flied within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Home Maker 18. Mother's Name (First, Middle, Meiden Sumeme) Maryland 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be t nent of Hesith and Mental I 5 Lester Cunningham Eva Bell Shavender 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) of Health. Eugene Trapani Husband 20b. Place of Disposition (Neme of cemetery, cremetory or other place).

June 27, 1998 Same as #10 Baltimore, other 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Alexandria, Virginia Metro Funeral Service 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd. Indian Haad, Md. 20646 shock, or heart faure. List only one cause are each line. Onset and Death **Physician** tmmediete Cause (Finel disease or condition resulting in deeth) /Medical CANCER COLON MO. Examiner Due to (or es e consequence of): Examiner ATZATAM The law requires that the death certificete be executed bunal-tran Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest and Box 68760 Physician/Medical the Due to (or es e consequence of): use as P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 40 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings evellable prior to completion of cause of death? page 2 should Completed 24e. Wes en eutopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes cese referred to medicel examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 leftient 2 ER/Outpetient 3 DOA 1 Yes 2⊒(No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Dete of Injury (Month, Dey 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. tnjury et Work? 5 Pending investigation 1 TYes 2 □ No within 24 hours after death. To the Funeral Director: A 2 Accident 3 Sulcide Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homlcide Hospital Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical vieteldmos (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 120 D-283526 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Krishan Mathur, MD P.O.Box 2729 La Plata, Maryland 20646 JUN 3 0 1998 Dalla Diwelson Rordall 31. Dete filed (Month, Dey, Year) State

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Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	or its	by Funeral Director	11. Maritei Status 1 Never Marriad 2 Merried 3 Widowed 4 Divorced	12. Was Dacedant Armed Forcas? 1 ☐ Yes 2 X If Yas, Giva Yaar or Datas:				lispanic Origin? (S en, Mexican, Puai	Specify Yes or N to Rican, etc.)		ce - American Inc ck, Whita, etc.	
	n 72 hours "natural", edical Exp	8	15. Decedent's Ed	lucation		16a. Decedan	t's Usuel Occup	pation		16b. Kind ot B	usinass/Industry	
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	of He	١	20a. Method of Dispesition	Damoual from State	20b. Plac	ce ot Dispositi natary, cramat	on (Name of ory or other pla	ce)	Data	20c. Location	- City or Town, S	tata
-	Peg ment ant: I		4 Donation 5 Other (Specific	2 A	Mary	/land V	eterans	s' Cem.	7-2-98	Cheltenh	nam, MD	
	permit. Peges 1 end Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Fundral San Josephon Mark G. Broha	3 mm M0005	jan	Hur		eral Home 156, Wal		D 20604	0156	
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	requires been sign should be	Completed by								s an autopsy ormed?	24b. Wara au available completi ot death'	prior to on of cause
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			30. Nama and address of person who	omplated cause of d	eath (Item Of	3a) /Time Di	nt)	-		-	,	200
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32. Begistrar's Signature

State Registrar

31. Data filed (Month, Dey, Year)

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	or 28	Director	10e. Street and Nun					10f. Zip				10g. Citize	n of What Co	untry?	
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State Registrar

d (Month, Day, Year)

32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma		ertificate of	Death	, ,	g. No.	8 2	1180
	Dharalai		1. Decedant's Name (First, Middla, Las	1)				2. Data of Deeth Month	1	Yaar 3.	Time of Death
	Physici /Medic		DONALD BALDWIN WO	OD				June 24			:55 AM
	Examir		4e. Facility Name (If not institution, giva	street and number)			4b. City, Town, or L	ocation of Death	4c. County of		
		,	Citizens Nursing	Home			Frederick		Freder	cick	
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Ē	Page ento nt: If i		1 Burial 2 Cramation 3 1 4 Donation 5 Other (Specify,			own Cremat		5/25/98 H	acarata	rm Vo	beeleve
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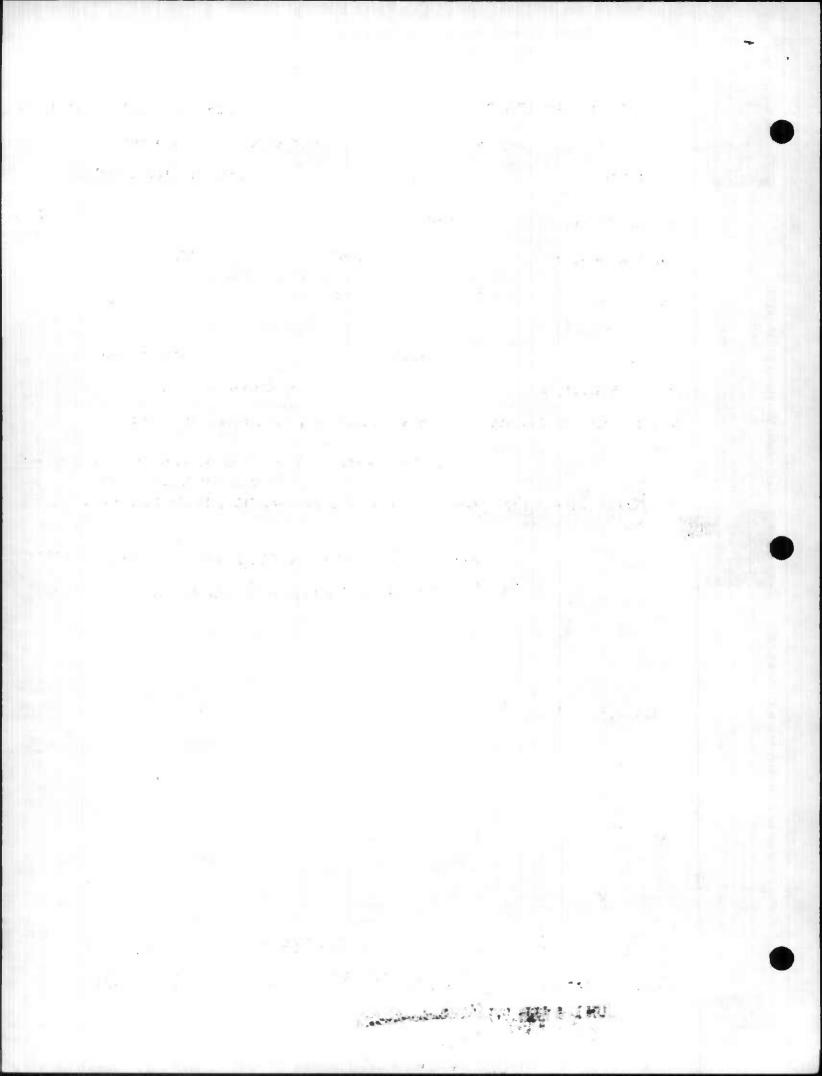
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Dete of Death Month 06 **Physician** Williams 5:44 pm Huthony /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth **Examiner** Center Cheverly PRINCE Hospital PRINCE GEORGES GRORGE If Under 24 Hrs. 8! Date of Birth (Month, Dey, Year) Feb. 22, 1 If Under 1 Year 6. Sex 1 M 2 F Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthdey) 5. Social Security Number **Funeral** Months Days 1957 Washington, D.C 41 577-80-2687 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Prince George's Maryland Capitol Heights 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20743 504 Suffolk Ave. United States Funeral 12. Wes Decedent Ever In U.S.
Armed Forces?
1 MB Yes 2 © No 8/3/75
If Yes, Give
Year or Dates: 9/1/79 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 Never Merried 2 Married Specify: Black 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Postal Worker Elementary/Secondary (0-12) College (1-4or 5+) 12th Mail Handler 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Dorothy Dyson Grafton Eugene Williams 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Name/Relationship (Type, Print) 6314 Elmhurst St. District Heights, Maryland 20747 Eugene G. Williams/ Brother 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Buriel 2 Cremetion 3 Removal from State Maryland Veterans Cem. 6/29/98 Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Alexander S. Pope Funeral Homes 23a. Parti, Inter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike/Forestville, Maryland 20747 Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) MASSINE Tulmonan Examin Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Hypercoag wable Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of). CERRBRAC VAsculor Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown FORAMEN OVOLS py 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Was en eutopsy 1 Yes 2 No 25. Was case referred to medicel exeminer? Be 26. Place of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) ↑ SInpatient 2 ER/Outpatient 3 DOA 27. Manger of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Matural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

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31. Date filed (Month, Day, Year) JUN 26 Registrar

3 ☐ Suicide

29a. Certifier

4 I Homicide

(Check only one)

30. Name and address of person who p

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) Certifying Phyeicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture and title of certifie 29c. License number

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29d. Date signed (Month, Dey, Year)

led cause of deeth (Item 23a) (Type, Print) Alexandria Ave 5268 DAWES

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death JUNE 16,1998 **Physician** WHITE 6:03 pm **LARRY** /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 5710 MIDDLETON LANE CAMP SPRINGS PRINCE GEORGES Sex 11 M 2 □ F If Undar 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (Stata or Foreign Country) 7. Aga (In yrs. last birthdey) 8. Data of Birth (Month, Day, Year) **Funeral** Months Deys Hours Min. 48 Yrs. 244-80-3528 JAN 19,1950 Director North Carolina Usual Rasidance of Decedant permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show eny injury or other traumatic event, the Mexical Example must be northed at page. 10a Stata 10b. County 10c. City, Town or Location 10d. Ineide City Limits 1 Yas 2 □ No Directo Maryland Prince Georges Camp Springs 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Coda 5710 Middleton Lane 20748 United States Funerai 12. Was Decedent Ever In U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-iff Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Rece - American Indian. 11. Maritel Status Bieck, White, atc. 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 XMarried altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) Contractor Home Improvement Private 18. Mothar's Nama (First, Middla, Maidan Surname) 17. Fethar's Nama (First, Middla, Last) Rogia White Nora Heath 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, State, Zip Coda) Elessa D. White / Wife 5710 Middleton Lane, Camp Springs, Md. 20748 20a. Method of Disposition 20b. Placa of Disposition (Neme of cematary, cramatory or other place) 20c. Location - City or Town, Stata Data 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) RESURRECTION CEMETERY 6-20-98 CLINTON MD 21. Signatura of Funaral Sarvice Liquision 22. Name and Addrass of Facility ALEXANDER S. POPE FUNERAL HOMES M85 2617 Pennsylvania Avenue, SE DC 20020

23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Gustric Sarcama immediata Causa (Final diseasa or condition rasulting in death) /Medicai Metastatic **Examiner** Dua to (or as a consequence of): Examine the death certificate be axecuted attending physician and for use es the bunal-transit Sequentially list conditions, if any, laading to Immadiata causa. Enter Underlying Causa (Disaasa or injury thet initiated avants Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): rasulting in daeth) Last signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not rasulting in the undarlying causa givan in Part I. 1 Yes 2 No 3 Probably 4 Unknown The law requires thet Division of Vital Records, by 24b. Wara autopsy findings available prior to been si 24a. Was an autopsy performed? Completed complation of causa of death? certificate has b irector, page 2 s 1□ Yes 2□No 1 □ Yas 2 □ No or Attanding Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Homa 5 Pesidance 6 Othar (Specify) 9 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannagef Death 28c. Injury at Work? 28d. Dascribe how Injury occurred 28e. Data of Injury (Month, Day Year) 28b. Tima of Certification: After 1 BNatural 5 Panding 1 Yas 2 No Invastigation eftar death. 2 Accidant Director: / 6 Could not be datarmined 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28a. Placa of Injury - At homa, farm, straat, fectory, offica building, atc. (Specify) 4 | Homicida A 24 hour. Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a. Certifian edicai To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifias 30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print) Wash. DC. 20032 1328 Southern Ave H? 20 MA 52200 31. Data filad (Month, Day, Yaar)

State Registrar

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32 Registrar's Signature

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** June 7:30Pm ADET.E WILLIAMS /Medical 4b. City, Town, or Location of Deeth 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner DOCTORS'S HOSPITAL LANHAM PRINCE GEORGE'S 5. Social Security Number tf Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2₽F 231-30-6742 Yrs. 67 Director MAY 19, 1931 VIRGINIA Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 ☐ Yes 2 ☐ No Director VIRGINIA NORTHUMBERLAND HEATHSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 291 BIRCHALL LANE 22473 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Completed by AFRO AMERICAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 9 HOUSEWIFE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Pages 1 end 2 should be nent of Health end Mental LAWERENCE SUTTON ADA MITTON 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health e Important: If Item 27 Is any injury or other tre once. JOHN WILLIAMS 291 BIRCHALL LANCE HEATHSVILLE, VA 22473 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriat 2 Cremation 3 Removal from State □ Donation 5 □ Other (Specify) SHILOH BAPTIST CHURCH 6/25/98 BURGESS, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BERRY O. WADDY LANCASTER, VA 22503 P.O.BOX 305 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final CARBIAC MUTES disease or condition resulting in death) Examiner Examiner 1401KG RES PIRATORY buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, 51+=71C CARDIOMYOPATITY MUNTHS Physician/Medical Due to (or as a consequence of) (0んにもといいの HEART FAILURE P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate hes been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown CELL LYMPHUMA þ Records. 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? CULUNARY BRTERY DISEASE completion of cause of death? 2E No 1 Yes this certificate 1 ☐ Yes 2 ☐ No Division of Vital Physician: Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) 1□ Yes 2☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours aftar death. To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Coutd not be determined 3 Sulcide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manoer stated. 29a. Certifier

To the

State Registrar

Medical

31. Date filed (Month, Day, Year)

JUN 25

29b. Signature end title of certifier

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George H. Bone, MD 1100 Mercantile Lane Ste 135 Largo, MD

29d. Date signed (Month, Day, Year)

29c. License number

231069

was a first of the state of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First Middle Last) 2. Data of Death 3. Time of Death **Physician** Month MAY 26 FRANCIS LEO 1998 YOUNG 9:30 AM /Medical 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Undar 1 Year | If Undar 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** 1X M 2□ F Yrs. 010-30-4291 59 Director March 23, 1939 Massachusetts Usual Rasidanca of Dacedant death with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. inslda City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Florida Clay Director Orange Park 1 Yes 2 No 10e. Street end Numbar 10f. Zip Code 10g. Citizan of What Country? United States 2910 Andy Court 32065 Completed by Funeral of America 12. Was Decedenf Everinus. Armed Forcas? 1955-1X Yas 2□No 1977 IYas, Giva Yeer or Datas: Vietnam 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status filed within 72 hours after 1 Naver Married 2 XMarried 21215-0020 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowad 4 ☐ Divorced White 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decadent's Education 16b. Kind of Business/Industry (Spacify only highast grada complated) Collega (1-4or 5+) Elementary/Secondary (0-12) permit. Peges 1 and 2 should be filed within Department of Health end Mantal Hygiene. Important: If item 27 is marked other than eny Injury or other traumatic event, the Man Injury or other traumatic event, the Man Injury or other traumatic event, the Man Injury or other traumatic event, the Manual Injury or other traumatic event, the Manual Injury or other traumatic event, the Manual Injury or other traumatic event, the Manual Injury or other traumatic event, the Manual Injury or other traumatic event, the Manual Injury or other traumatic event. Supply Technician Defense Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Melden Surnama) Be Leo F. Young Abbie Dudley 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Sandra Law Young/ Wife 2910 Andy Court, Orange Park, Florida 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) June 5, 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Putnam Crematory 1998 Interlachen, Florida 21. Signatura of Funarel Sarvice Licensae 22. Name end Address of Fecility Jacksonville Memory Gardens Funeral Home & Cousen Cemetery, 111 Blanding Boulevard, Orange Park, FL 23a. Pert1. Entar tha diseasa, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiratory arrest, shock, or haert tailure. List only one cause on eech line. Approximate Intarval Batw Onset end Death **Physician** /Medical Immediate Causa (Final MULTI ORGAN SYSTEM FAILURE disaasa or condition rasulting in death) 2 WEEKS Examiner Due to (or es a consequanca of): Examiner buriel-transit The law requires that the death certificate be executed and Sequantially list conditions, if eny, laading to immediata causa. Entar Underlying Causa (Disaase or Injury that initiated avants rasulting in deeth) Last Due to (or es a consequance of): P.O. Box 68760. Physician/Medical the Due to (or as a consequanca of): USB **urrector**: After this certificate has been signed by the a in by the funeral director, page 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ◯ No of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica Be 25. Was case rafarrad to madical 26. Placa of Daath (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatiant 3 DOA 10 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Division 1 Neturei 5 Panding invastigation 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straet and Number or Rurel Routa Number, City or Town, Stata) 4 I Homicida 29a. Cartifian 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the Within 2 To the I 29b. Signature and title of certifie 29c. Licansa number 29d. Date signed (Month, Day, Year) D-45356 u 30 Name and eddrass of person who completed causa of deeth (Item 26a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER M.W.MITCHELL, LCDR, MC, USN BETHESDA MD 20889-5600 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registra JUN 1 0 1998

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death edent's Name (First, Middle, Last 2. Date of Death **Physician** 4b. City, Town, or Location of Deesh /Medical Name (If not institution, giva street and number) 4c. County of Death **Examiner** Union Hospital Elkton Cecil 5. Social Security Number 6. Sex 1. M 2□ F if Under 1 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 215-18-4562 78 Yrs 1919 Pennsylvania Director Usual Residence of Decedent deeth with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director Cecil Maryland Charlestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Tasker Lane 21914 USA Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. filed within 72 hours efter 1 Navar Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 21215-0020 1 ☐ Yes 2 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced WW II White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Pages 1 end 2 should be filed within the Health end Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Forklift/Crane Operator Manufacturing Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Charles Young Martha Comack 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Heelth e If item 27 is r or other tra Beatrice M. Young/Wife 408 Tasker Lane Charlestown, MD 21914 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Ramovai from State permit. Page Depertment of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Memorial Gardens 7-1-98 Broomall, PA 22. Name and Address of Facility
T. Foard Funeral Home, P. A.
11 S. Queen St. Rising Sun, 21. Signature of Fune al Service Licensee R. 111 MD 21911 ichar Part 1. Enter the disease, or complications the coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner the burial-transit The law requires that the death certificate be axecuted Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Due to (or as a consequence of): for use as ate has been signed by the a page 2 should be datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 Unknown Records. þ Be Completed 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to complation of cause of death? 2 1 No certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director. 25. Was cese referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 2010 3000A Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 6 ☐Other (Specify) this in by the funeral 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. injury et Work? After 5 Pending investigation 1 Naturel 1 Yes within 24 hours after death To the Funeral Director; A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide filled To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. completely (Check only one)

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In

State Registrar 31. Date filed (Month, Dey, Year) JUN 3 0 1998

29b. Signature and title of certifian

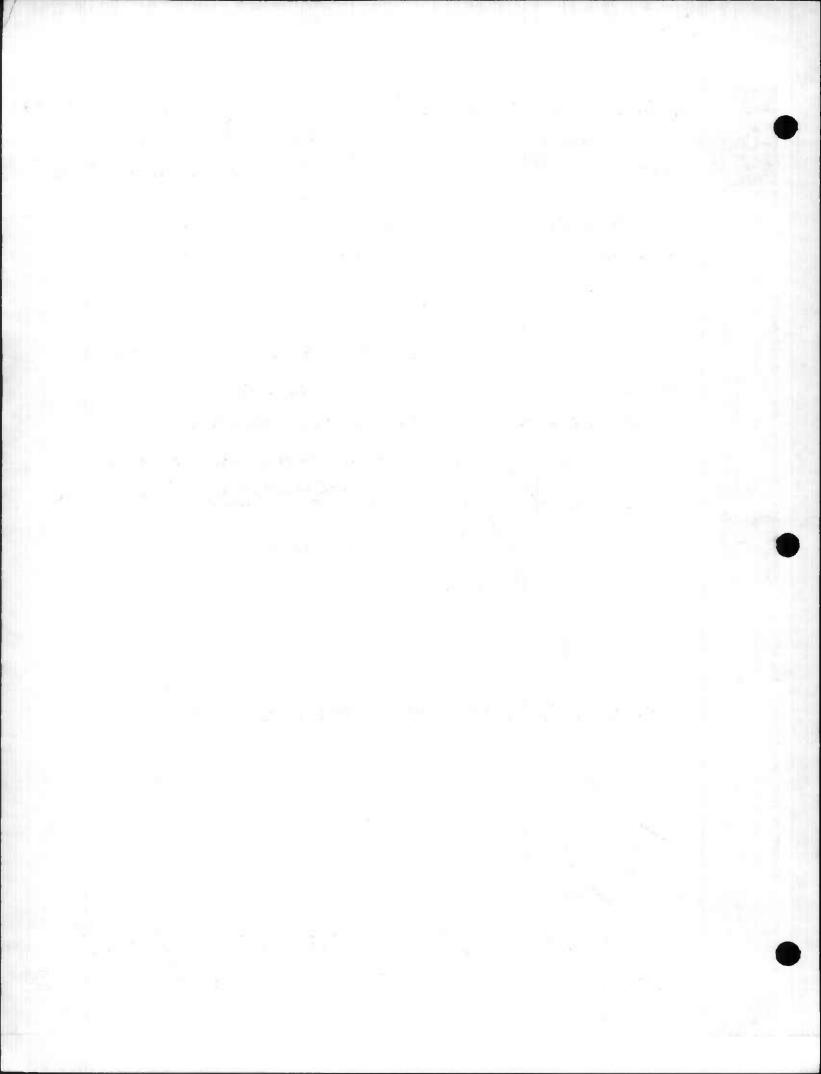
32. Registrar's Signature

of deeth (Item 23e) (Type/ Print)

29c. License number

29d. Data signed (Morth, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month **Physician** Mary M. Ahlquist 1998 8:15 pm July /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15103 Pirate Lane Prince George Laurel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Min 1 M 2 TF Hours 86 212-26-5106 Director Jan. 23,1912 Minnesota Usuel Residence of Decedent the Maryland 10d. fnside City Limits 10a. State 10b. County 10c. City. Town or Location "natural", or items 23s or 28s-f show 1 Yes ZNO Director Maryland Prince George Laurel 10a. Street and Number 10f. Zin Code 10g. Citizen of What Country? 15103 Pirate Lane 20707 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: p 3 XXVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Ø Receptionist Heating & Air Conditio 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental Hanti litem 27 is marked off lary or other treumatic even Be Thomas A. Bowser Mary McCormick 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Lenore Simons/Daughter 3201 Greencastle Road, Burtonsville, Maryland 20866 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Weuriel 2 Cremation 3 Removal from State St. Mary's Church Cem. 7/11 Laurel, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Neme end Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707

The or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest,

Approximate 23a. Parts Enter the dis Approximate fntarval Between Onset and Death **Physician** /Medical Cardiac arrest Immediate Causa (Final disease or condition resulting in death) Examiner Examiner arrhy thoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated evants resulting in death) Last Due to (or as e consequence of) evomory, Box 68760 Physician/Medical Due to (or es e consequence of) requires that the deeth certifical for use Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. P.O. 23h. Did tobacco use contribute to the cause of death? Deleve 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yas Mo Division of Vital or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Date of fnjury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Neture 5 Pending Investigation 1 Yes 2 No 24 hours efter death.

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2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) within 2 5

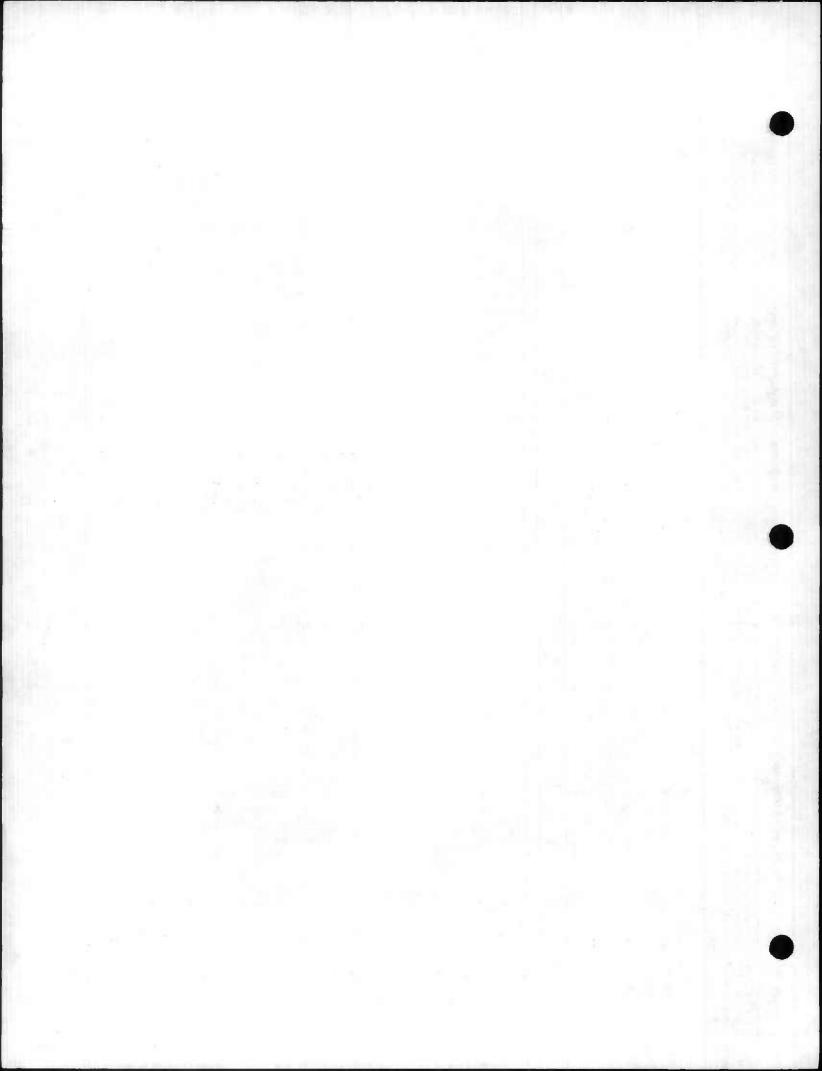
30. Name and address of person was completed cause of death (Item 23a) (Type, Print) Laurel Park DV. Laurel MD- 20707. 14201 31. Date tiled (Month, Day, Year) 1998 32. Repsirece Springer Con Landell

State Registrar 29b. Signature and title of certifier

29c. License number

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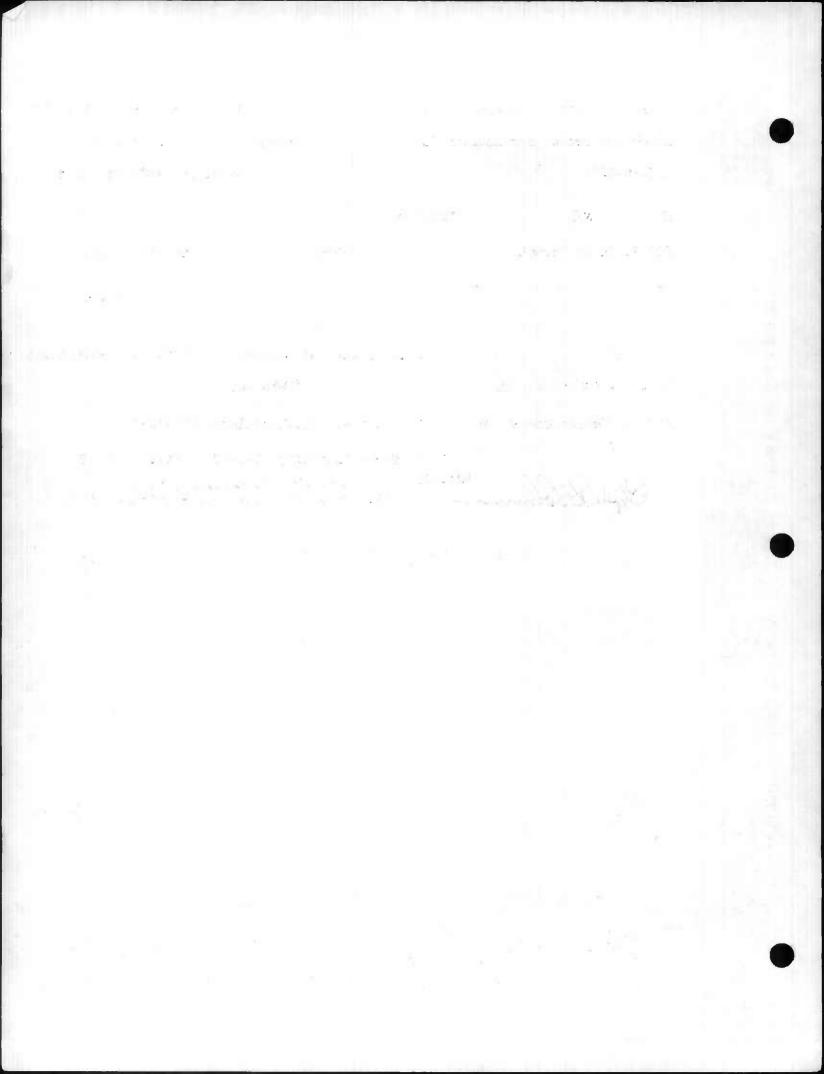
29d. Date signed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene 8 2 | 8

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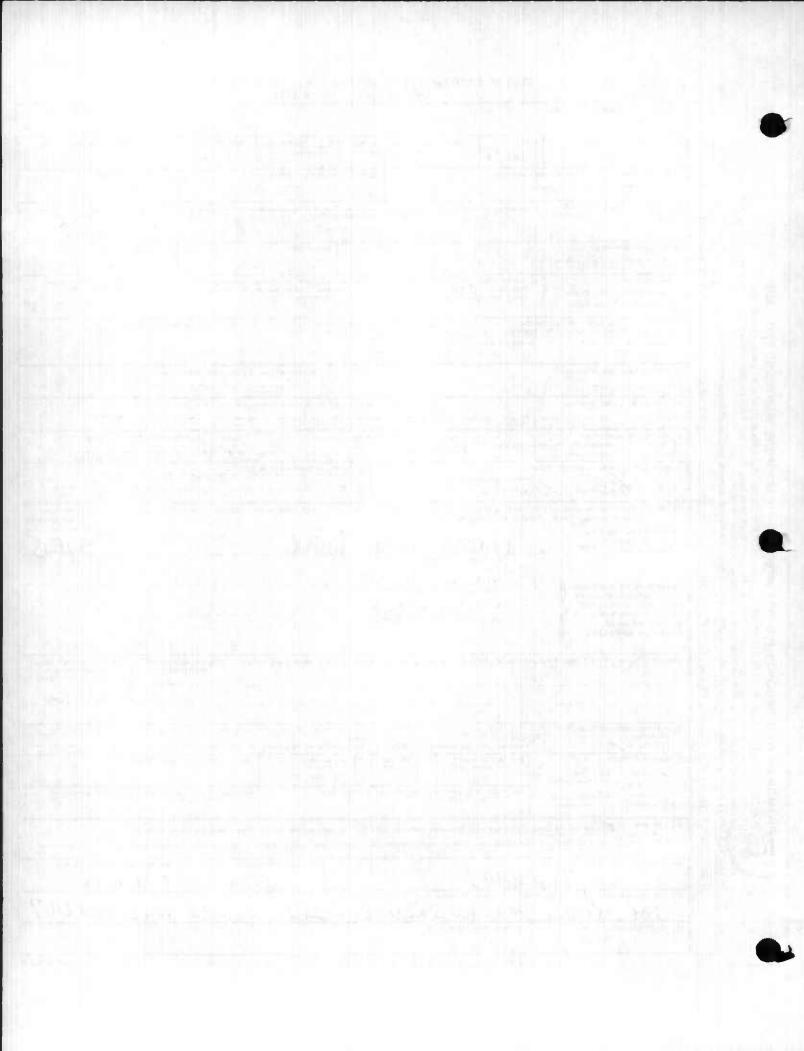
BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physician.

the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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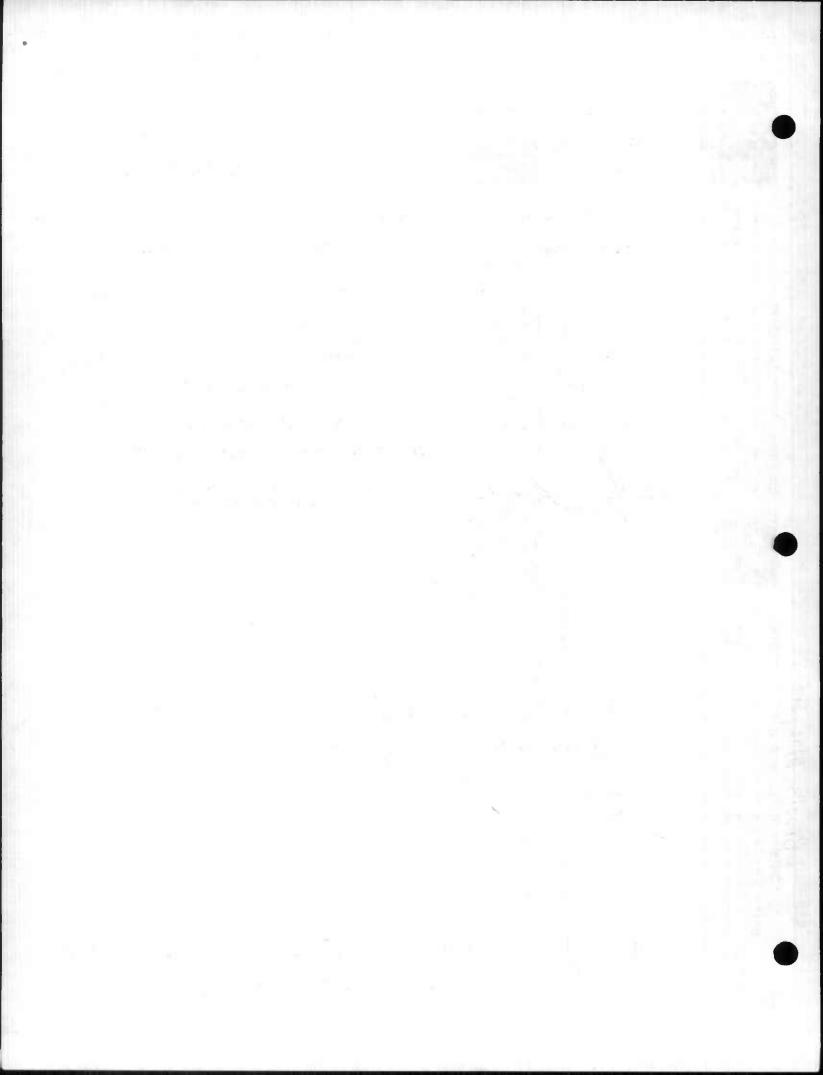
1 - STATE REGISTRAR	STATE OF MARY	AND / DEPART			MENTAL HYGIEN				
1. DECEDENT'S NAME (First, Middle, Lest) BERNICE ALLEN					2. DATE OF DEATH DATE OF JULY 06.	W YEAR	3. TIME OF DEATH 7:45AM		
4. SOCIAL SECURITY NUMBER 438-26-8710	1 🗆 M 2 💢 F	79 YRS.	IF UNDER 1 YEAR	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10/26/191	Cou	THPLACE (State or Foreign ortry) MER, LA		
90. FACILITY NAME (If not institution, give 131 GRIST STONE W.				OR LOCATION OF D	EATH	BALTIM			
10a. STATE 10b. COUNT GA MUSC			TOWN OR LOC				10d. INSIDE CITY LIMITS? YES 2 NO		
100. STREET AND NUMBER 944 PEMBROOK DRIV	E			31907			WHAT COUNTRY?		
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	11. MARITAL STATUS 1 Never Married 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES. GIVE WAR OR DATES				NIC ORIGIN? (Specify Yes an, Puerto Rican, atc.) fy:	Bio	CE — American Indian, sck, White, etc. ec/ly: BLACK		
15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1.2	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use HOMEMAK	rk done during : retired.)		16b. KIND OF BUS	SINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) HUGH DANSBY		HOMEMAK	EK_		AME (First, Middle, Maiden	Surname)			
190. INFORMANT'S NAME (Type/Print) NEHWANDA WASHINGT	ON/DAUGHTER			t and Number or Rural	Route Number, City or Town	n, State, Zip Code)	21117		
20q. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Ren 4 Donation 5 Other (Specify)	roval from State Co	b. PLACE AND DATE OF metery, cremetory or oth ORT MITCH	er plece) ELL NA	TIONAL CE	M.7/10/98	CATION — City of FORT MI			
21. SIGNATURE OF FUNERAL SERVICE LI	Harl		STER		ON FUNERAL AVE. CATO				
iMMEDIATE CAUSE (Final disease or condition resulting in daeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a type J DUE TO COT AS a WHEN	A CONSEQUENCE OF SCHOOL A CONSEQUENCE OF A CONSEQUENCE OF A CONSEQUENCE OF	ites s	ilvæ			interval Batwe Onset and Dea		
PART II. Other significant condition	ns contributing to death	but not resulting in	tha undariy	ng cause given in	Part i. 24a. WAS AN PERFOR	MED?	4b. WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 70		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 TO	HOSPITAL:		OTHER:	PLACE OF OEATH (C					
27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. I	NJURY AT YORK? YES 2 NO	28d. DESCRIBE HOW II	DAUGHTER'S RESIDENCE V INJURY OCCURED			
2 Accident Investigation 3 Sulcide 8 Could not be 4 Homicide determined	281. LOCATION (Street a City or Yown, State)	ON (Street and Number or Rural Route Number, Own, State)							
	ICIAN: To the best of my know						e(s) and manner as stated.		
29b, SIGNATURE AND TITLE OF CERTIFIE	ominmo			29c, LICENSE NU	MBER 500	29d, DATE SIGN	ATE SIGNED (Month, Day, Year)		
JAY LIPIMAN		85 RED	RUN	GLVD	CONINO	MILLS	MOZ1117		
31. DATE FILED (Month, Day, Year) JUL 1 0 1998	32. REGISTRAR'S SIG	den-Bidel	2						



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State of Maryland / Department of Health and Mental Hygiene

		1 Decedents Name	e (Ciest Middle 1 e	-41		С	ertificate o	f Death	10.000.40	Reg. No.	1	
Physici /Medic	al		BROOKS		- 5 1			4h Cihi Taum	2. Date of D	Day	1998	3. Time of Death
Examin Funeral	er	4a. Fecility Name (# 54. Agh 5. Social Security No. 216-14-00	15 H3501	tal	7. Age (In yrs	s. last birthde Yrs	Months Day	Baltin Under 24 Hi		th 4c. County Balt inth Bay, Year) 5, 1921	9. Birthpia	ace (State or Foreign
Director		Usuel Residence of	Decedent						001 1.	0,1921	BALTO).,MD
n tha Marylan r 28a-1 show Inotified	ctor	MD State	BALTII	MORE	10e. C	ARBI					10	d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with th	Funeral Director	10e. Street and Num 5608 HUNT		AD			10f. Zip Code 212			U.S.A.	What Countr	ry?
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itema 23a or 28a-f show raumatic event, the Medical Examinating must be notified at	by	11. Maritai Status 1 ☐ Never Marrie 3 ☒ Widowed	ied 2 Married	12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	rces? 2 No e	U,S. 1	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 N		(Specify Yes or Norto Rican, etc.)	14. Rad Bie Specif	ce - America ck, White, ei	tc.
Hygiena. Yther than "natur ent, the Med cal	Completed	(Special Elementary/Second 10TH GRA		ucation de completed) College (1	-4or 5+)	16a. De (G life	cedent's Usual Occ ve kind of work don DO NOT use reti	ne during most of w red)	orking	16b. Kind of B	usiness/Indu	ustry
la b o	Be	17. Father's Neme (ame <i>(First, Middle</i>		ne)	
and Mental I is marked of raumetic eve	To	19e. Informant's Na		ype, Print)		19b. Me	oiling Address (Stre				State, Zip C	Code)
Departmant of Health and Mer Important: If Item 27 is merke any injury or other traumetic once.		20a. Method of Disp Buriai 2	H. BROOK: position Cremation 3 5 Other (Specify	Removal from S	20b.	Place of Dis	HUNTSMOO position (Name of rematory or other p ARK CEME		Date 7/13/98	MD. 2 20c. Location BALTI	City or Tow	m, State
Departrumporta any inju		21. Signeture of Fur	rat Service Licen	1/	1.0		22. Name and Add IUBBARD FI					
		23a Partt Enter the shock, or hour	ne dineane, or comp t failure. List only	plications that ca	used the cea	ith. Do not	107 WILKI	ENS AVENU ying, such es cardi	E-BALTIN ec or respiretory	MORE, MD	2122	29 Approximate Interval Between
hysician /Medical xaminer		Immediate Cause (I disease or condition resulting in deeth)	Final	a	Sep	515	sequence of);					Onset and Death
and and	Examiner	Sequentially list con if any, leading to im- cause. Enter Under Ceuse (Disease or I that Initiated events	nditions, imediate	b	N (C)		NIA sequence of):	stie Syn				
ding physical and a second	edical	Ceuse (Disease or I that Initiated events resulting in death) L	Injury ast	d	Due to (or as a cons		7510/71	1 d Pone			
he attendi ed for use	Physician/M	Pert II, Other signific	cant conditions	entributing to de	ath but not re	sulting in the	underlying cause	given in Part I.	23b. Dio	I tobacco uas co	ntribute to 1	the cause of death?
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has been sig e 2 should b	Completed t		Inte	rstiti	4	Chi	g Dr		24a. Wa	s an eutopsy formed?	com	re autopsy findings iable prior to apletion of cause seth?
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hyan d dra	2	examiner? 1 Yes 2 2 27. Menner of Death 1 Natural 2 Accident	No	28e. Date o (Monti	npatient 2 [Injury h, Day Year)	ER/Outpa 28b. Time Injur	of 28c, Ini	other: 4 Nursing	Home 5□ Res			
eral Director filled in by the	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place	of Injury - At t ig, etc. (Speci	nome, farm,	street, factory, offic			(Street end Numi own, State)	ber or Rumai	Route Number,
Hospi 24 hou Funer tely III	edical	29a. Certifier (Check only one)	1☐ Certifying Phy 2☐ Medical Exam	relctan: To the laner: On the ba and mann	sis of exemin-	owledge, de etion end/or	eth occurred at the Investigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time	cause(s) and m , date and placa,	enner as ste end due to t	ited. the cause(s)
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Sta	te	31. Dete filed (Month		-	gistrar's Sign		Rolling	Kd (a	tonsull	(MP		

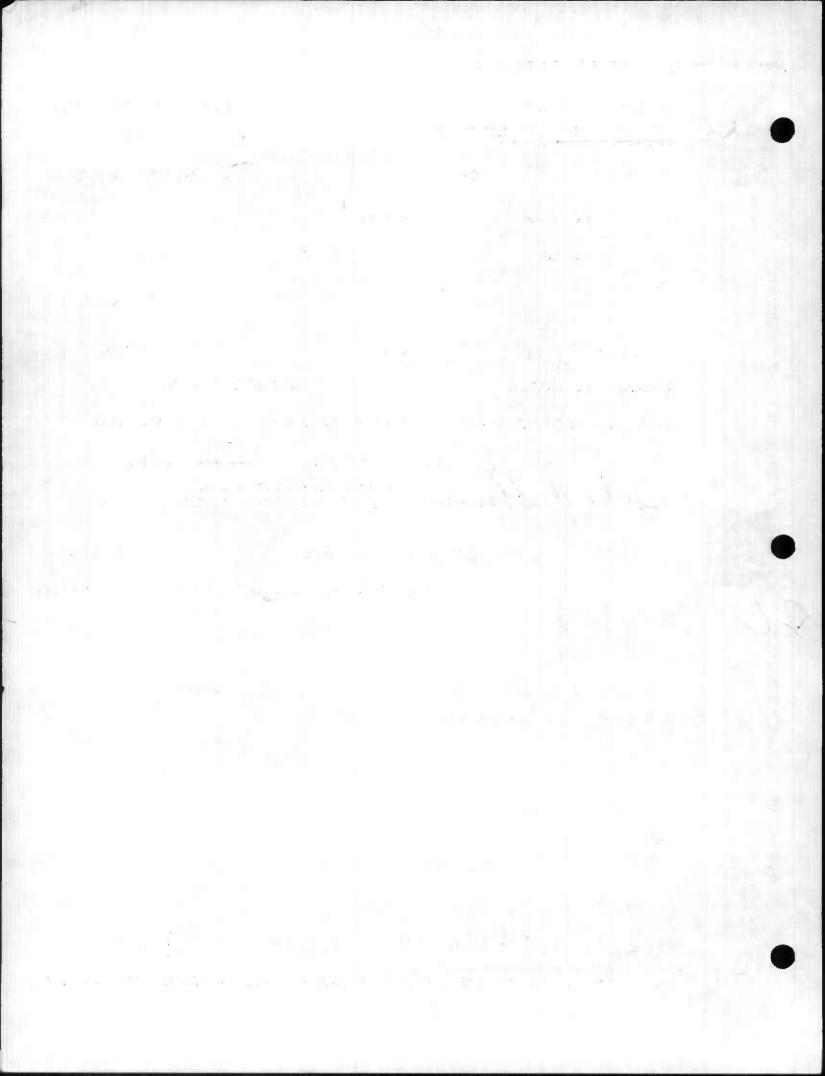


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State of Maryland / Department of Health and Mental Hygiene

Amend: #4a Per MD.20b Per FH Film G761 7-10-98RC Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dala of Death 3. Time of Death 24, 1998 **Physician** EDWARD A. BRUCKNER JUNE 7:55PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number)
ST. AGNES NURSING & REHABILITATION CENTER
-EDWARD-AUGUST BRUCKNER Examiner EDWARD AUGUST ELLICOTT CITY HOWARD If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dev. Year) 9. Birthplace (State or Foreign **Funeral** Months Deys Hours 1☑M 2□F Yrs. 212-09-9768 Director 89 12,1908 BALTO., MD Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itama 23a or 28a-f ahov 1 Yes 2 No Director MD BALTIMORE ARBUTUS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 5603 HUNTMOOR ROAD 21227 permit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a any injury or other traumatic event, the Modesi Express 1 and 26. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yas 2 □ No WW If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married WW II Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b Kind of Business/Industry Fiementery/Secondary (0-12) College (1-4or 5+) CLERK PRINTING 9TH GRADE 18. Mother's Name (First, Middle, Malden Sumema) 17. Father's Name (First, Middle, Last) FREDERICK G. BRUCKNER ELIZABETH REIGGER 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 5603 HUNTMOOR ROAD - ARBUTUS, MD. 21227 HENRY R. BRUCKNER (BROTHER) Baltimore, 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 6/27/98 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 6/17/98 BALTIMORE 21. Signature of Funeral Service Licenses 22. Name end Address of Facility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onsal and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Respiratory Failure **Examiner** Physician/Medical Examiner Recurrent MEN MMM Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760 Due to (or es a consequence of) law requires that the deeth cartificate he for use es signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown Azhermers Demento ò 24b. Were autopsy findings available prior to completion of cause of death? should st 24a. Wes en eutopsy Completed s certificate has b director, page 2 s 1□ Yes No 1 Yes 2 No or Attanding Physician: director, 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending Investigation 1 Neturei 1 Yes 2 No 2 Accident ofter death Director: / 6 Could not ba determined 3 Sulcide 28f. Locallon (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours efter the Funeral Dire npletely filled in b 11 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier within 2 To the I To the 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print) DR. WILLIAM J. KORDON - 4801 DORSEY HALL ROAD-SUITE-201-A-ELLICOTT CITY, MD 21042 31. Date filed (Month, Day, Year) 1998 32. Registrar's Signature State Randell wha Dayson Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** -adams 0030 neodone 1-1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Regional Salis bury
If Under 24 Hrs. 8. Dete of Birth Center. (eninsula Wicomico 7. Age (In yrs. last birthday) If Under 1 Year Months Deys 6. Sex 1 M 2 F 8. Dete of Birth (Month, Dey, Year) Z-Z--O 9. Birthplace (State or Foreign Country) 5. Sociel Security Number **Funeral** Hours Min. 213-07-8564 MARYLAND Director Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23s or 28s-f show Examiner must be notified at Mary Land 1 Yes 2 No Worcester Director Berlin 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? STREET 21811 U.S. of AMERICA death v Funeral MEA 12. Wes Decedent Eyer in U,S. Armed Forces? 11. Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Healith and Mental Hyglene. Important: If item 27 is marked other than "natural", or ite any finlury or other traumatic event, the Modest Essentia 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 22 No Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) Coilege (1-4or 5+) Detective ENTONCEMEI NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be SNiegowski Louis Important: If item 27 is mark, any injury or other traumed-2 0/0 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Horne Daughten 4425 No Canal

20b. Place of Disposition (Name of cametery, cremetory or other place) N. Fort Myers CAROLE SEAbolt Circle 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 □ Cremetion 3 □ Removai from Stete Dandalk ROSARY 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Ki-ChaTNACK. F. 1.1-5 5 Dundalk Ave 100 and the death. Do not enter the mode of dying, such as cardiac or respiratory erre 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Physician /Medical Immediate Cause (Finei disease or condition resulting in deeth) 5 days Examiner Due to (or es e consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Wes an autopsy performed? ticoaquilation -1 Yes 2 LNo 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this 28a. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of injury 28d. Describe how injury occurred Certification: 28c. injury at Work? 1 Naturei 5 Pending investigation Fell. 2100 1-2-98 level sur r death. 1 Yes 2 HNO ace 2 DAccident after death 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Creek Ketinement luc 24 hours Hospitai 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifier completely (Check only one) within 2 To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year)

1).M.E

relia Davidson-Randalle

Sulkeley 30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

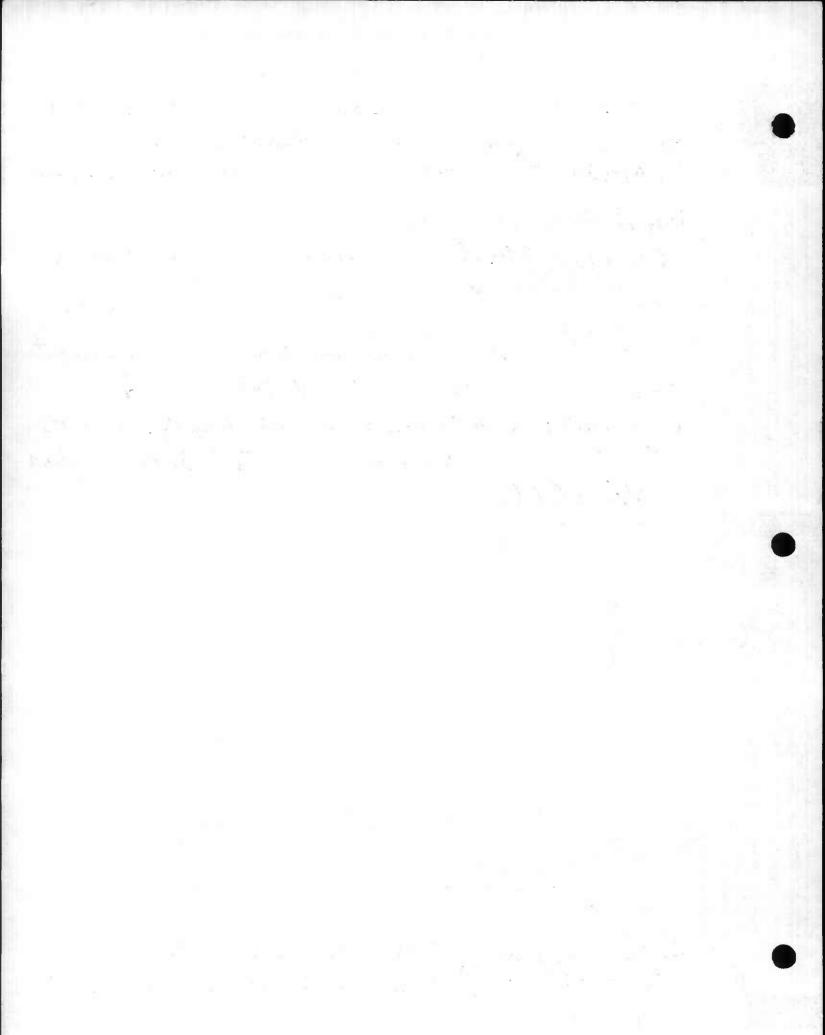
Bultzeley TM 7 Year) 32. Register's Signature

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108 Pine Bluj Rd., Salishuny, Md

Registrar

) ann 31. Dete filed (Month, Dey, Year) JUL 1 0 1998



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State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Margaret Bondaruk July 1998 0730 am 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Laurel Regional Hospital Prince George Laure1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 18, 1932 9. Birthplace (State or Foreign Country) New Hampshire 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 TF Days Hours 003-22-6361 65 Yrs. Director Usual Residence of Deceden Departs. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, its Medical Exercises. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Yes 2 No Prince George Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 318 Carroll Avenue USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes A ANO If Yes, Give Year or Dates: 11. Meritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ANO Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Theodore Brown Lorna McKenny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Morris/Daughter 1013 Philip Power Drive, Laurel, Maryland 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burlal 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Washington Cr. 7/9 Laurel, Maryland M Funeral S 22. Name and Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 plicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Plemal Effusion Examiner Due to (or as a consequence of): and HyporIbumenemia 3 wks Proteinemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest rrhos: 5 Division of Vital Records, P.O. Box 68760 Ut Physician/Medical Due to (or es a consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown GasTRO Intestinal Bleedin 24b. Were autopsy findings evelleble prior to completion of cause of death? Completed 24a. Was an autopsy Massive Ascites 200 No 1 Yes 1 Yes 2 No I or Attending Physician: after death. Director: Aftar this cartifica 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 2 ☐ Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital 24 hours a Funeral C 29a. Certifier (Check only one) To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical To the Vithin 2 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) mer no 120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daive Beltsuille Md 20705-1757 11305 Pitsea · Jones MD Gary

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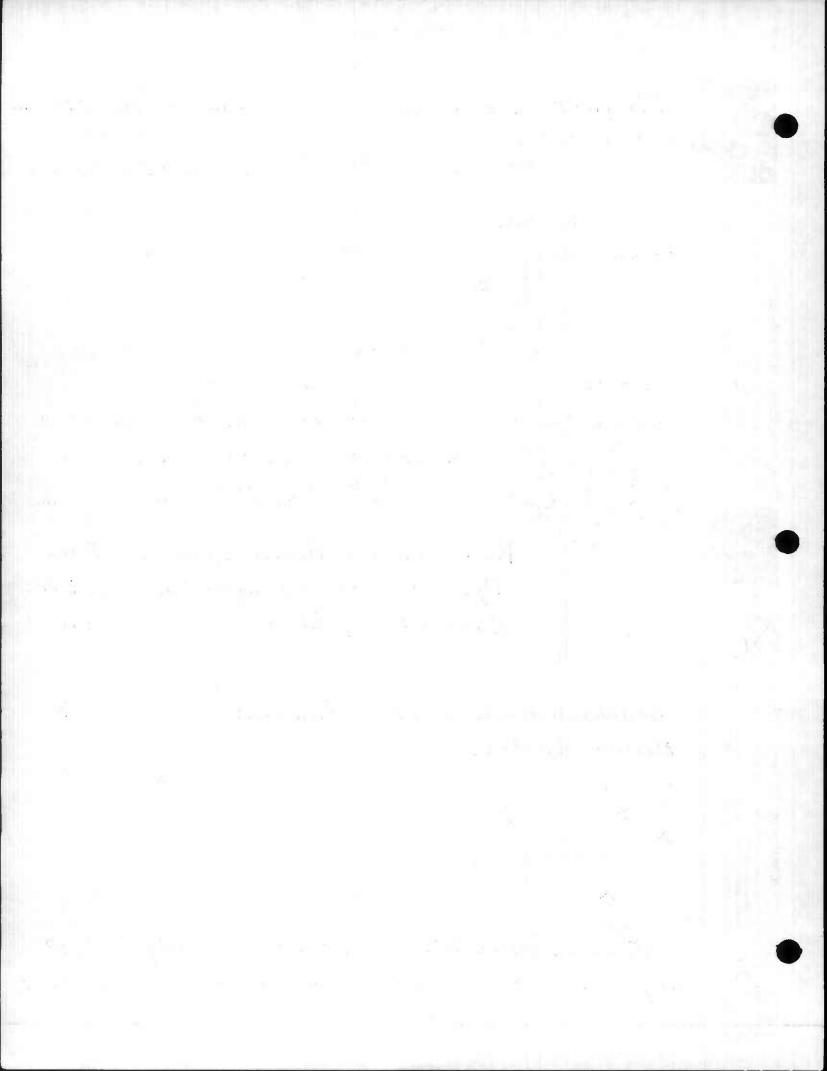
Registrar

31. Date filed (Month, Day, Year)

JUL 1 0 1998

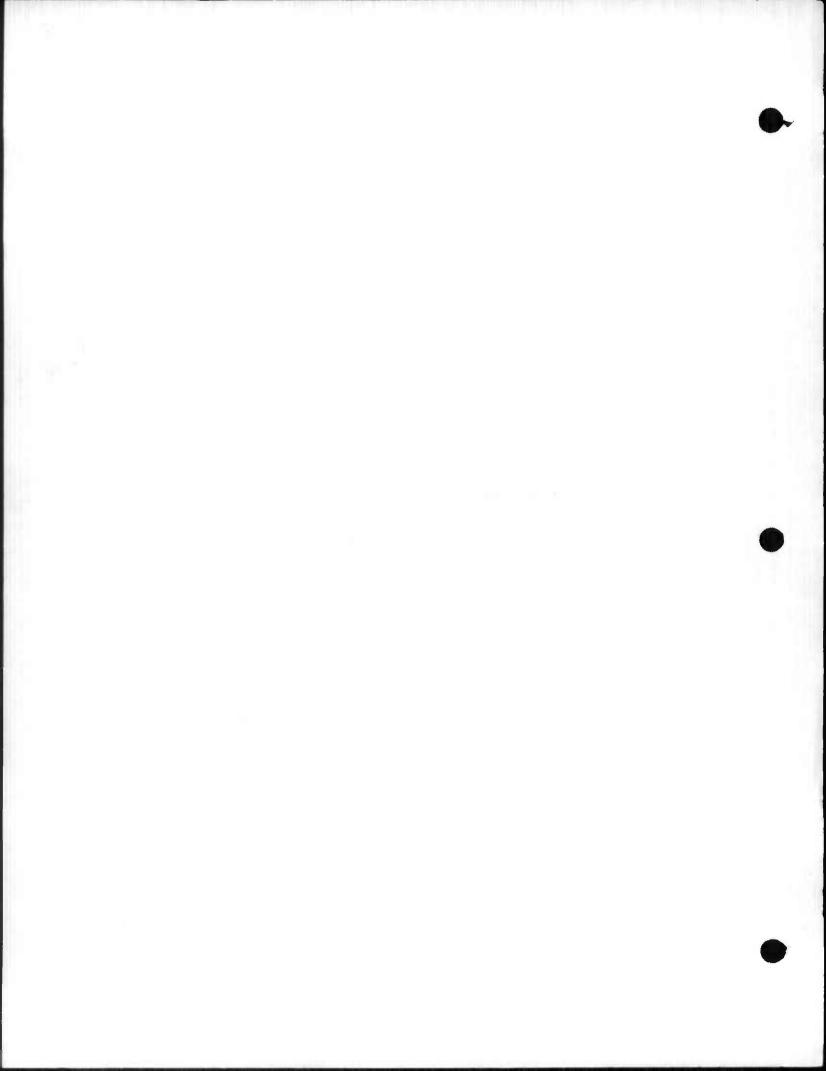
32. Registrar's Signature

Tulia Davidson-Randell



BALTIMORE, MARYLAND 21215-0020	thar death. Page 6 may be retained by the hospital or attending physician.	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should oval.	al examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	ENT OF H	EALTH AND W	IENTAL HYGIEN		-1170		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF GEATH		3. TIME OF DEATH		
	Terese Baltika					July 9,	1998	6:00a M		
		- X	MOI	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year)	Count	HPLACE (State or Foreign		
	9a. FACILITY NAME (If not institution, give stree	09						thuania		
=	1017 Elmridge A			altim	O L' S	ATN	Baltimo			
DISECTOR	RESIDENCE OF DECEDENT						DOLOZINO	71.0		
	Maryland Balti	more		timor			10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN OF Y	1 TYES 2 NO		
UNERAL	1017 Elmridge A	venue		2	1229		United			
5		2. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPANI	C ORIGIN? (Specify Yes	or No — 14. RACI	E — American Indian, k, White, etc.		
	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA		1 TYES	2 NO Specify:	Puerto Micen, Mc.)	Spec			
3	15. DECEDENT'S EDUCAT	ION	18a. DECEDENT'S USU	AL OCCUPATION	N.	16b. KIND OF BU	SINESS/INDUSTRY	WIIICG		
9	(Specify only highest grade cor Elementary/Secondary (0-12)	College (t-4 or 5+)	(Give kind of work life. Do NOT use rel	tred.)				On 1		
L L	12		Meat Pr	ocess	or	Meat P	rocessi	ng		
3	17. FATHER'S NAME (First, Middle, Last) Tomas Galinaiti	S				€(First, Middle, Melden tankevic				
	t9a. INFORMANT'S NAME (Type/Print)		196, MAILING ADI	ORESS (Street a		oute Number, City or Tow	240			
2	Eugenija Drazdy	s, sister						e,MD21104		
	20a-METHOD OF DISPOSITION 1 D Burial 2 Cremetion 3 Remove	I from State com	PLACE AND DATE OF DI	SPOSITION (Na	me of	OATE 20c. LO	CATION — City or To	wn, State		
ı	4 Donation 8 Other (Specify)	N	ew Cathe	dral	Cemeter	7/11Ba1	timore,	Maryland		
1	201111				J. Wabs		al Home			
4	- + OQ (gan		5311	Edmonds	on Ave.	Balto.,	MD 21229		
	23. PART i. Enter the diseases, or com shock, or heert fallure. Lis	t only one cause on a	the deeth, Do not e ach line.	enter the mo	le of dying, auch	as cardiac or respi	ratory arrest,	Approximata interval Between		
	IMMEDIATE CAUSE (Finel disease or condition	Acute Cer	NhmoT	himas	hock			Onset and Daeth		
	resulting in death) a	DUE TO (OR AS A	CONSEQUENCE OF):	WUVVC	100013					
	Sequantially list conditions,									
	if any, laeding to immediate cause. Enter UNDERLYING	OUE TO (OR AS A	CONSEQUENCE OF):							
2	CAUSE (Disease or injury that initiated eventa	DUE TO (OR AS A	CONSEQUENCE OF):							
	reaulting in death) LAST							-		
	PART II. Other significent conditions c	ontributing to deeth b	ut not resulting in th	e underlying	ceuse given in P	ert i. 24a. WAS AN	AUTOPSY 24b	WERE AUTOPSY FINDINGS		
							MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
								OF DEATH? 1 YES 2 NO		
	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL				UNCERTAIN					
	EXAMINER?	OSPITAL:		HER:	./					
	27. MANNER OF OEATH	□ Inpatient 2 □ ER/Outp	28b. TIME OF	28c. INJU	5 Masidenca 8	Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCUREO			
	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	M t Y	RK? E\$ 2 \(\) NO					
	3 Suicide 8 Could not be	26a. PLACE OF INJURY building, etc. (Speci	— At home, farm, street	, factory, office		28f. LOCATION (Street a City or Town, State)	nd Number or Rural F	loute Number,		
				City or Town, State)						
	(Check only									
	2 MEDICAL EXAMINER: C	In the basis of axamination	and/or investigation, to	my opinion, de			d dua to the cause(a) and manner as stated.		
	De Coulus Hou	1~		- 1	LANC 13	ER 29	29d. DATE SIGNED	(Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA	ATN (ITEM 27) (Type, Print)	1003 13	21	HULL	3571101		
	Laura J Harla	n 25 ma	un strees	+ Rei	stees tou	ur MD	2/13/			
	31. DATE FILED (Month, Day, Year) JUL 1 0 1998	32. REGISTRAR'S SIGNA	NON-Mandall			1.10				
100		 ¬¬ www./¬w///// 	TO SELLY AND A PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PAR							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Dete of Death 3. Time of Deeth 4:00 pm **Physician** Pearl Breckenridge 4b. City, Town, or Location of Death /Medical 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Baltimore Sinai Hospital 6.5ex Baltimore City | If Under 1 Year | If Under 24 Hrs. | 8. Deta of Birth (Month, Day, Year) | 1 - 20-1900 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 20℃F Months 98 Yrs. 218-36-6389 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28s-f show traumatic event, the Med cal Examinat must be notified at NA Baltimore 1 Yes 2 No Md Directo 10e. Street and Number. 10f. Zip Code 10g. Citizen of Whet Country? eguola Avenue 36/2 21215 Funeral 12. Wes Decedent Ever In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 4. Race - Amaricen Indian, Black, White, etc. 11. Merital Status 1 ☐ Nevar Marriad 2 ☐ Marriad 1 Yas 20 No Specify: Specity: Black by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Private College (1-4or 5+) Jomestic Work NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Cornelia amuel 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/5 Andre Breckenridge Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory, or other place) Avenue 20a. Mathod of Disposition Data 20c. Location - City or Town, State Important: If its any injury or o once. 1 Buriel 2 Cremation 3 Removel from State Cathedral Baltimore, Md 7-13-98 4 ☐ Donetion 5 ☐ Other (Specify) Ceneter 22, Name end Address of Fecility 21. Signature of Funerel Service Licensaa lad 4 300 Hd Zizis ferenue wow Wabash 23a. Part1. Enter the disease, a complications that ceusad the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 3 weeks · Intra-abdomina Examiner Due to (or as a consequence of): Exploratory laparotomy Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Causa (Disease or injury that initiated events resulting in daeth) Last Due to (or as a consequence of): Ischemic bowel Due to (or as a consequence of) Incarcerated Olvision of Vital Records, P.O. Box Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Left lower lobe preumonia by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed MI certificate has b lirector, page 2 st 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes cese referred to medicel examiner?

1 Yes 2 No Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this letely filled in by the funeral di 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation 1 Yes 2 No 2 Accident 8 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital edicai 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) end menner as stated. within 24 hou To the Fune completely fi 2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Shillings. (Jones & Ph.D. DO (G-Y-1)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AS 2402321-59

Shelley A. Quarless PhD, DO, Sinai Hospital, 2401W Belvedere Ave, Baltimore, MD 21215
31. Deterlied (Month, Day, Year) 32. Registrer's Signeture

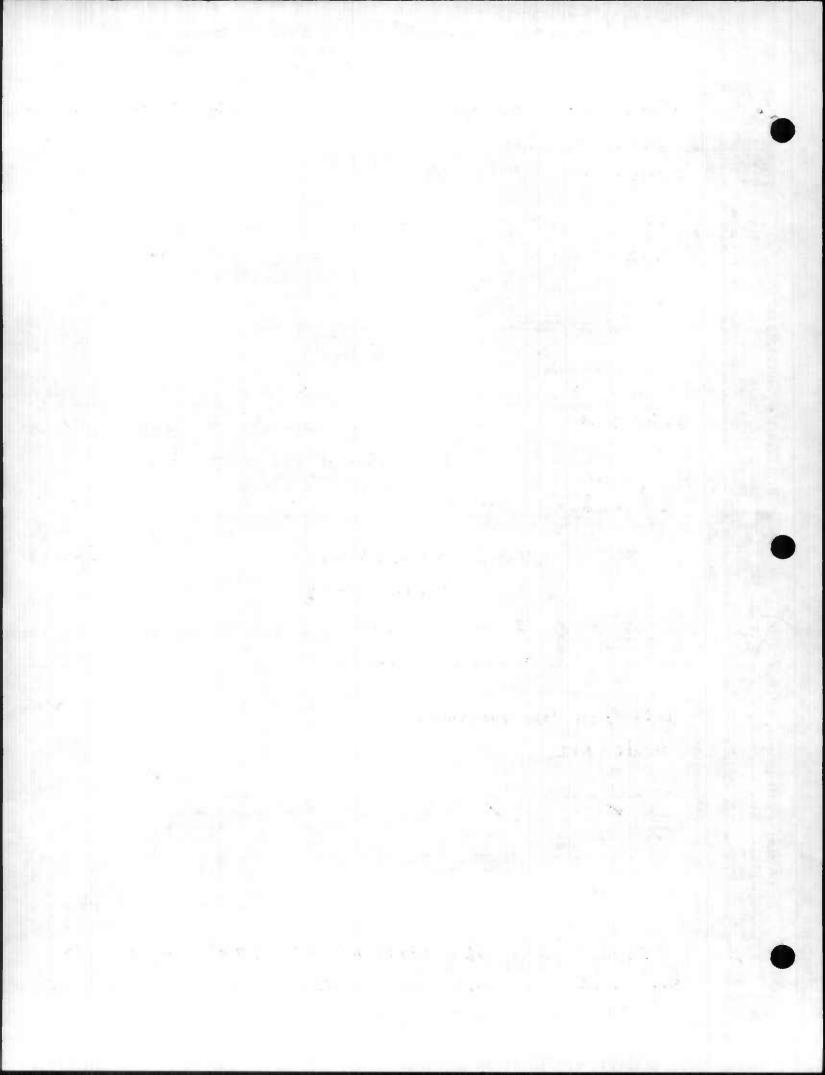
his Davidson-Randell

Registrar

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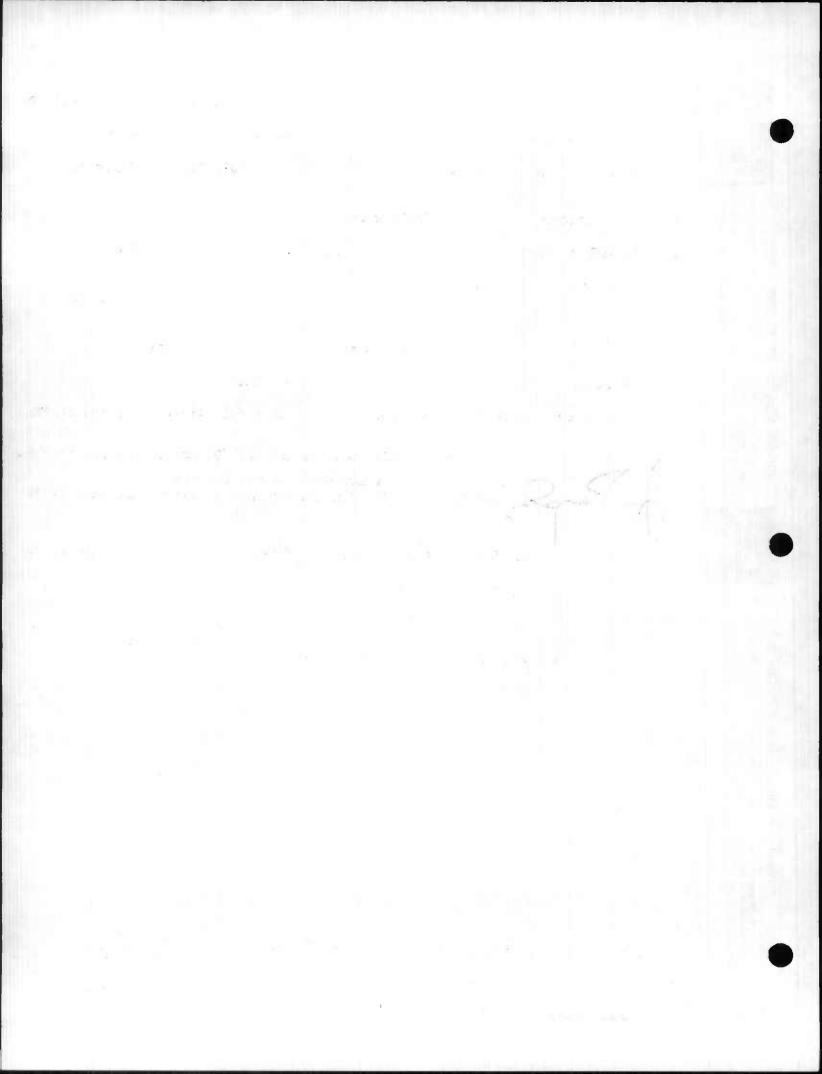
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7998 Yaar July 8, **Physician** 10:15 PM Howard William Bateman /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Dundalk Baltimore Eastpoint Nursing Center If Undar 24 Hrs. If Under 1 Year 8. Data of Birth
July 21, 1908 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foraign **Funeral** Min. Months Davs 1₩ 2□ F Hours Tennessee 89 238 10 8599 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limita death with the Maryler r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Baltimore Directo Middle River 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7 Right Rudder Court 21220 Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yas 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status Pages 1 and 2 should be filed within 72 hours efter ment of Health end Mental Hygiene.
Ant: If item 27 is marked other than "natural; or the way or other traumatic avent, in a Medical Estantial by or other traumatic avent, in a Medical Estantial. 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 2 No Specify: Specify: p White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilega (1-4or 5+) Machinist Shoe Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Laura Cole A. T. Bateman 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7 Right Rudder Court Middle River, Maryland 21220 Mildred P. Bateman (wife) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If Holly Hill Mem. Gardens 7/11/98 Balto. County, Maryland Donation 5 ☐ Other (Specify) 22 Name and Address of Facility PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a Part Enter the disease, or heart failure. List complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each lina. Approximate Interval Between Onsat and Death **Physician** a. CARDIOKULMONARY ARREST

Due to (or as a consequence of): /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner DEHYDRATION
Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and INSULINDEPENDANT
Dua to (or as a consaquanca of): Division of Vital Records, P.O. Box 68760, DIABETES Physician/Medical the MELLITUS FIBRILL ATION 80 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Onknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Attending Physician: Be 25. Was casa referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and piace, and due to the causa(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Baltinone 2 Marriel Bri voler 31. Date filed (Month, Dey, Year) 32. Registrar's Signature Juna Davidson Mandall State

DHMH 16 Rev 6/95

Registrar

JUL 1 0 1998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1 Decedant's Nama (First Middle Last) 2. Date of Death 9,1998 **Physician** 20 6:25 am dA /Medical 4s Facility Name (If not institution, give street and nu County of Death Examiner timore Birthplaca (Stata or Foraign Country) ial Security Number Age (In yrs. last birthday) **Funeral** Days TOM 20F 219-06-5835 Usual Rasidanca of Decedent Director VASTO 10a. Steta 10b. County 10c. City, Town or Location 10d. insida City Limits 1 1 1 1 No VASTO Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6605 TA Funeral Wes Decedant Evar Armed Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indien, 11. Marital Status in U.S Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Dates: 1 □ Nevar Married 2 □ Married 1 Yas 20 No Specify: white þ 3 E Widowed 4 □ Divorced Completed 16a. Dacedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16h, Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) OUN 5 18. Mothar's Nama (First, Middla, Meidan Sumama) 17. Fathar's Neme (First, Middla, Last) Be To ORIA MILION CHERE (ING. WIN) 19b. Malling Addrass (Streat and Number, or Rural Routa Number, City or Town, State 2 ip Code) 19a. Informant's Name/Relationship (Type, Print) HAREWOOD SANTORO 6819 PARK Cloti (Daughter) BAHON Ma 21220 lde 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - Oity or Town, Stets 1 Durial 2 Cramation 3 Ramoval from Stata STANI 4 ☐ Donation 5 ☐ Othar (Specify) SIAUS 22. Name and Address of Facility 100 - DabRows Ki 21. Signetura of Funaral Sarvice License - Chuj NACK. guised the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, BAlto. 23a, Pert1. Enter the disaasa, or complication, that shock, of heart failura. List only ona causa on Approximate fntarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in deeth) Examiner Physician/Medical Examiner SCHOOSI 0 Sequantially list conditions, if any, laading to Immediata causa. Entar UndarlyIng Cause (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Due to (or es e consequance of) Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 24b. Were autopsy findings available prior to Completed 24e. Wes an eutopsy performed? complation of causa of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical examinar? 26. Plece of Death (Check only ona) Be Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatiant 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accident 6 Could not be detarmined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Placa of Injury - At homa, farm, streat, fectory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760 The law requires that the death ce signed by the a peen s certificate has b or Attending Physician: director, this After n 24 hours after death.

Ne Funeral Director: At pletely filled in by the fu Hospital

with the Menyland

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Mapical Examinar must be notified at

important: If Item 27 is a sany injury or other traus

Department of Health and Mentel Hygiene.

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State Registrar 31. Date filed (Month, Day, Year) 1 0 1998

4 Homicide

(Check only one)

29a. Cartifier

29b. Signature

of death (Itam 23a) (Type, Print) 9000 32. Registrar's Signatura

Medical Examinar: On the back of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and magner stated.

29c. Licansa number

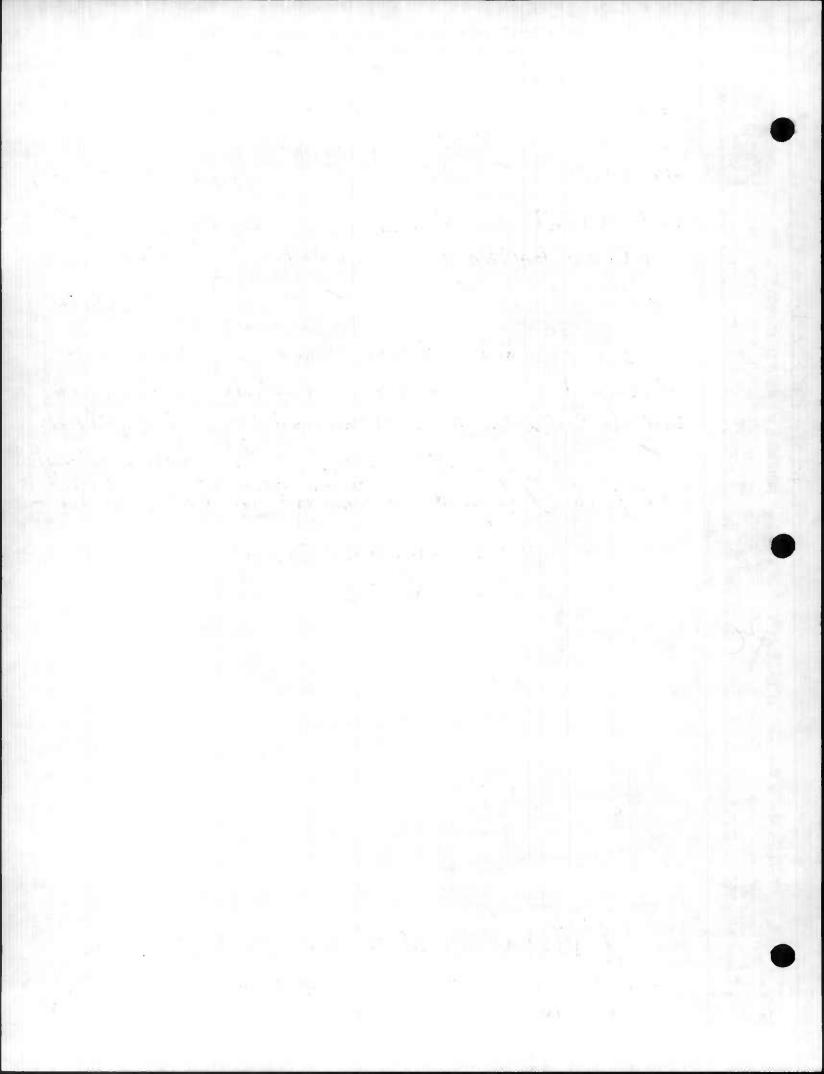
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[] Medical Examinar: On the basts of examination and/or investigation. In my opinion, death occurred at the time, date and place, and due to the

29d. Data signed (Month, Dey, Year)

Baltimore, MD 21237

whia Davids



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #1 Per MD ,17 Per FH Film G761 7-10-98RC Certificate of Death 1. Decedant's Nama (First, Middle Last) 2. Data of Death 3. Time of Death **Physician** Month CHANEY JAMES E. CHANEY, SR. 1998 07 02AM JU1-/Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Good Samaritan Hospital Baltimore n/a if Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) May 21, 7. Aga (In yrs. last birthday) If Undar 1 Yaar 5. Social Sacurity Number 6. Sax XXM 2□F Birthplaca (Stata or Foreign Country) **Funeral** Months Days 85 Yrs. 264-07-6996 Director 1913 Usual Residence of Decedent the Marylend 10a Stale 10b. County 10c. City, Town or Location 10d. inside City Limite 7 is marked other than "natural", or items 23a or 28a-f ehov traumatic event, the Medical Examinar insist be notified at XXYas 2 No Director MD n/a Baltimore 10e. Street and Numbar 10f. Zip Coda 10g, Citizen of What Country? 6608 Birchwood Rd, 21214 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-il Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, Biack, White, atc. permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mentai Hygiene. Important: if item 27 is merked other than "natural", or then any Injury or other traumatic event. 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas XXNo Specify: à Specify: Black. 3 Owidowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Flamentary/Secondary (0-12) **7th** Collega (1-4or 5+) Driver **Tractor Trailers** 17. Fathar'a Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) James S. Chanev Dorothy Howard 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 6608 Birchwood Rd. Balto., Md Hazel Chaney/daughter-in-law 21214 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata **Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Woodlawn Cemetery 7/13 Woodlawn, MD 21. Signare of Funaral Sarvice Licensea 22. Nama and Addrass of Facility

James A. Morton & Sons Funeral Home forter 1701 Laurens St. Balto., MD 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart tailure. List only one ceuse on each line. Approximata intarval Between Onsat and Death Physician /Medical Immediata Causa (Final . VENTRICULAR TACHYCARDIA. ASYSTOLE disaasa or condition resulting in daath) 20 MIN Examiner Dua to (or as a consequence ot): Examine ANTERO LATERAL MY OCARDIAL INFARCT buriel-transit Sequentially list conditions, if any, laading to Immadiata ceusa. Enter Undarlying Cause (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence ot): and be exec physician s the buriel-Records, P.O. Box 68760. CAROTO GENIE SHOCK Physician/Medical Dua to (or as a consequence of) Sensis Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did topecco use contribute to the ceuse of deeth? Yee 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to completion of cause of death? Completed has 2 No 1 Yas 2 No 1 Yas certificate Division of Vital 25. Was cesa ratarrage to medicel examiner?
1 Yas 2 V No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific. Be 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 (Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At home, tarm, streat, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Illed in by 4 Homicida edicai 29a. Certifian 12 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha ceusa(s) and mannar as statad.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner staled.

Good Scucrifer

lia Davidson

29c. Licansa number

Hospital 5601 Loch

29d. Data signed (Month, Day, Year)

901

MARY

To the Within 2

State Registrar (Check only one)

29b. Signatura and titla of certiliar

Daniana Anchede

Adriana Budhede MD.

JUL 1 0 1998

30. Nama and addrass of person who complated ceusa of death (Item 23a) (Type, Print)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 1998 1:40 PM 4e Fecility Neme (If not institution, give street and number) July /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Medica 5. Sociel Security Number ot Marylan 5 7. Age (In yrs. last birthday) 6. Sex 9. Birthplaca (State or Foreign **Funeral** Months Deys 216-32-5269 Usuel Residence of Decedent 1□ M 250 F Director the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examines must be notified at Maryland
10e. Street end Number 1 Yas 2 □ No Director mor 10f. Zip Code 10g. Citizen of What Country? Funeral death 12. Was Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 No
if Yes, Give
Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Meritel Status Bleck, White, etc. Pagas 1 and 2 should be filled within 72 hours after and of Health and Mental Hygiena.
nt: If Item 27 is marked other than "natural", or ite 1 Never Memied 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced American Atrican Completed 16e. Decadent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) omemaker de 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be en 10 19a, Informent's Name/Rejetionship 19b. Malling Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) (Type, Print) (Husband) ose 20e. Method of Disposition 20b. Pleca of Disposition (Name of semetery, crematory or other) 20c. Location -1 Buriel 2 □ Cremetion 3 □ F 4 □ Donetlon 5 □ Other (Specify) 3 Removel from State Department o injury or Son orest 22, Name end Address of Fecility 21. Signetare of Funeral Service Lifensee Joseph 2222 V Bny a W. North Aue. ter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or raspiratory heart failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical · Myo Cardia Examiner Due to (or es e consequanca of): Examiner Niseas & artery requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequença of) P.O. Box 68760 Physician/Medical Due to (or es e consequence of) 88 usa Por signed by the a d be datached i Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yss 2 ☐ No 48 Unknown Division of Vital Records, Parism requires the A 24b. Were autopsy findings evalleble prior to Completed 24e. Wes en eutopsy completion of cause of deeth? paga 2 has 1 Yes 2 □ No 1 Yes 2 No funaral director. 25. Wes casa referred to medical exeminer? Be 26. Placa of Daath (Chack only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 254 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Aftar this 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Streat and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical 12 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and mannar as stated.
2 Medicat Examiner: On the basis of exemphation and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated. 29a. Certifier completely To the To the To the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and the of certified

1998

MARKLAND

OF

State

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31. Dete filed (Month, Day, Year)

JUL 1 0 1998

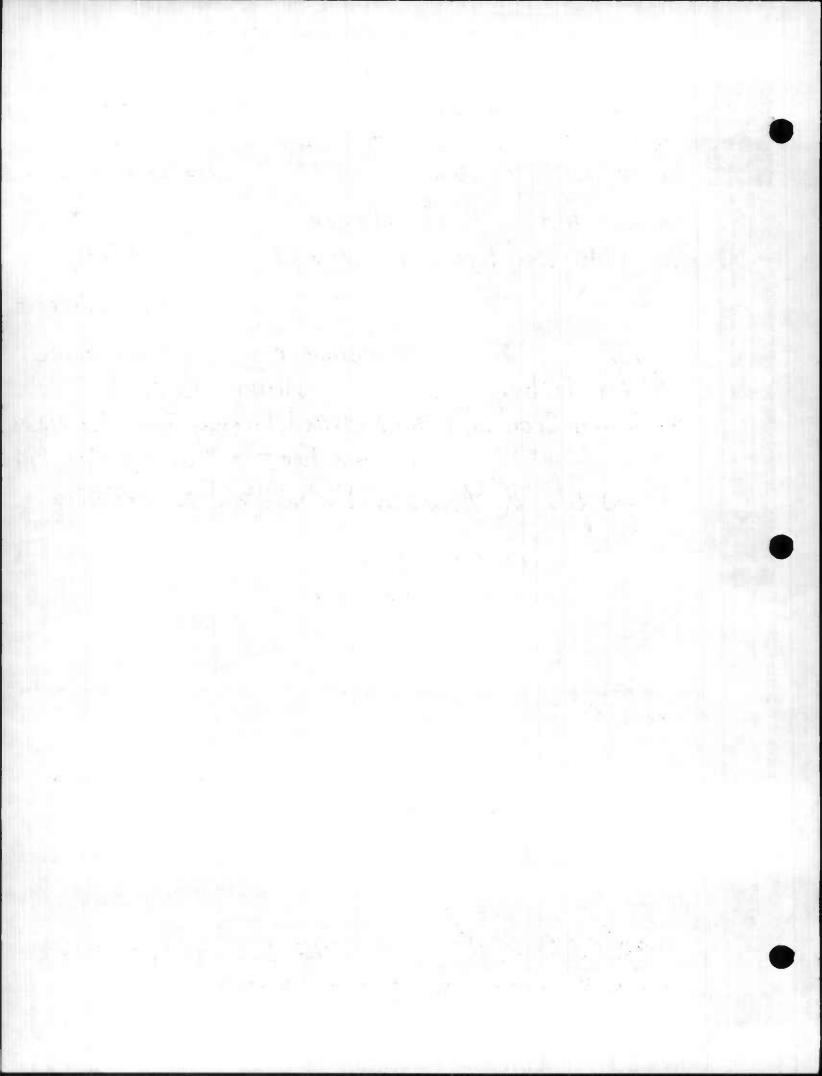
30. Name end address of person who complated cause of death (Itam 23a) (Type, Print)

BANKS

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LINE MESTALES SIGNAMANS

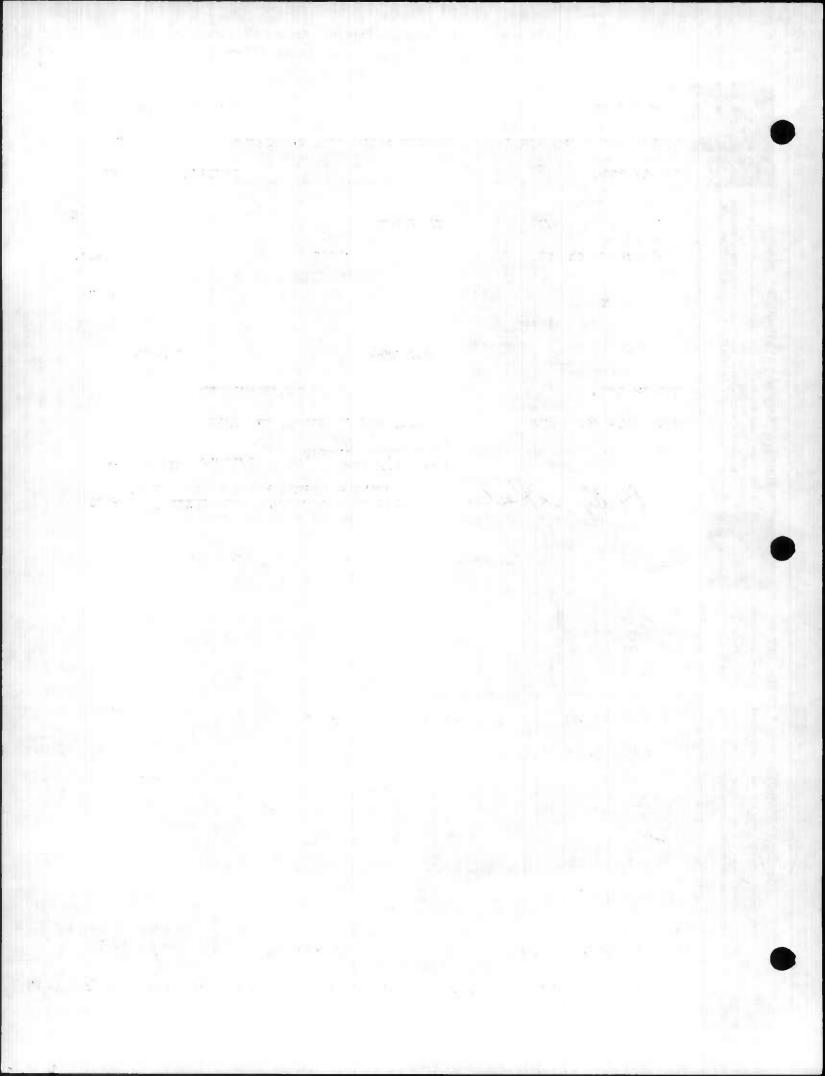
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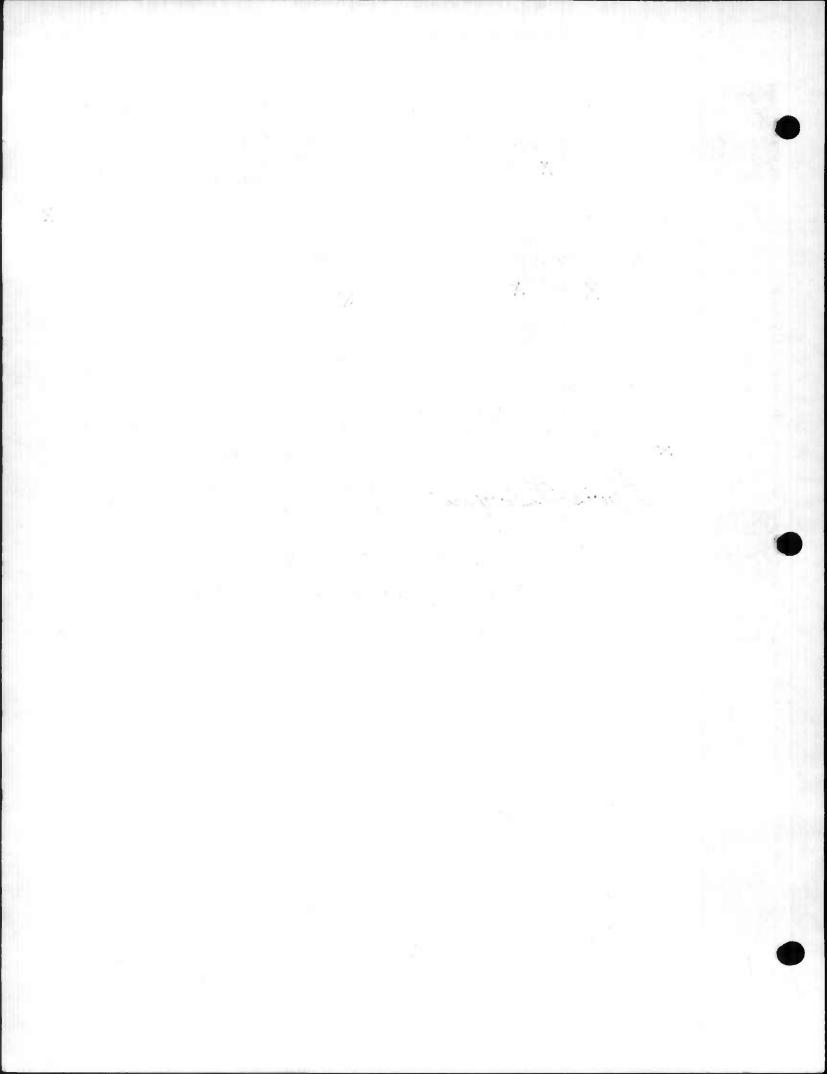
State of Maryland / Department of Health and Mental Hygiene

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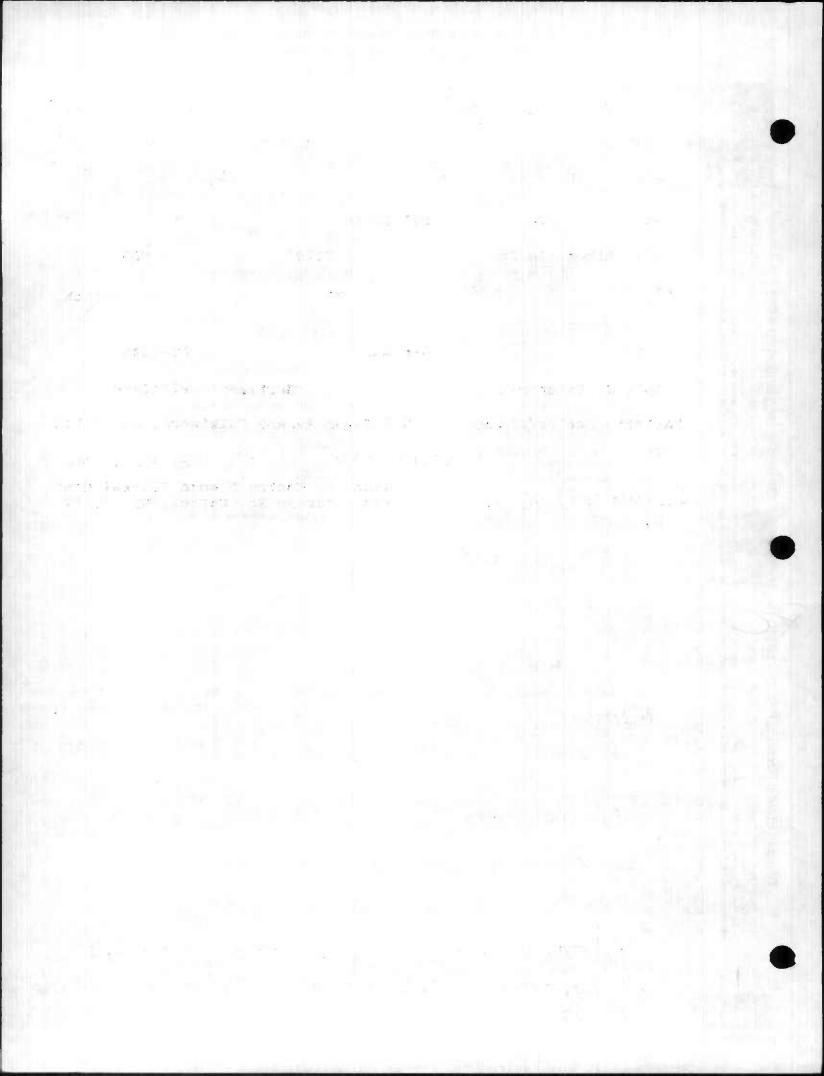
				Cer	tificate	e of I	Death			Reg. No.		
	1. Decedent's Name (First, Middle, L.	est)							2. Date of De Month	ath Day	Year	3. Time of Death
Physician /Medical	CAMDEN DALLIS CO	OL							JULY C			6:00PM
Examiner	4a Facility Name (If not institution, gi	va street and num	nber)		-	4	b. City, To	wn, or Lo	cation of Deat	h 4c. County	of Death	
	LORIEN FRANKFORD	NURSING	& REHABI	LITA	TION	CTR	. BAL	TIMO	RE		N/A	
al	5. Social Security Number 6.	Sex	7. Aga (In yrs. last	birthday)	If Under		If Under		8. Date of Bir (Month, Da	th Vens		elace (State or Foreign
or	232-12-2826	1⊠M 2□F	84	Yrs.	Months	Days	Hours	Min.	06/28/	1914	WV	nry)
	Usual Residence of Decedent											
rector	10a. Stata 10b. County		10c. City, To	wn or Lo	cation						1	0d. Inside City Limits
tor	MD N	/A	BALT	IMOR	E							1⊠Yes 2□No
9	10e. Street and Number				10f. Zip	Coda				10g. Citizen of	What Cour	ntry?
by Funeral Director	4603 MINNESOTA AV	/E.			2	120	6				U.S	5.A.
Jera	11. Marital Status	12. Was Dece	dent Ever in U,S.	13. V	Vas Deced	ent of H	ispanic Or	igln? (Sp	ecify Yas or No		ce - Amaric	
F	1 Never Marriad 2 Married	Armed For	2⊠ No						Rican, etc.)		ck, White,	
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	0	1	☐ Yes 2	No No	Specify			Specia	y: WH]	LTE
Be Completed	15. Decedent's E	ducation	16	a. Deced	lent's Usua	I Occup	ation			16b. Kind of B	usiness/Inc	dustry
plet	(Specify only highest gi	ade completed)	45-3	(Give I	kind of wor OO NOT us	rk done d se retired	during mos d)	st of work	ing	5411000		
E	Elementary/Secondary (0-12)	Collega (1-		ODSM	AN					SAWMII	L	
Ö	17. Father's Name (First, Middle, Las	r)					18. Moth	er's Name	e (First, Middle	, Maidan Sumai		
ä	BERLIN COOL						DED	muz	e T CUED			
7	19a. Informant's Name/Ralationship	(Type Print)	1	9h Meilla	n Arldraen	(Street			FISHER	er, City or Town	State Zin	Coda)
	HEDY COGAR/DAUGH								26217	or, only or roun	, Olulo, Lip	. 0000)
	20a, Method of Disposition				sition (Nam		TANA,	VV V	Data	20c. Location	- City or To	own State
	1008 Burial 2 Cremation 3	Removal from S	come				ST	- 1	Data	200. Location	- Oily of Te	, olulo
	4 Donation 5 Other (Spec	(fy)			METER			7	/11/98	DIANA	, WV	
SUCE	21. Signature of Funeral Service Lice	nsee at			Name and				מסאד ער	ME, INC		
	1 Hullio	Harl								ILLE, M		28
	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that ca	aused the death. D									Approximate Interval Between
Medical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or as	a conseq	uenca of):							
dicai	cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last	C	Due to (or as	a consequ	uence of):				-			
		d										
Be Completed by Physician	Part II. Other significant conditions	contributing to de	ath but not rasulting	in the ur	ndarlying ca	ause giv	en in Part	l.	23b. Dld	tobacco use co	ontribute t	o the cause of death?
Phy	TOALANA	05 50	- 11110101	1.7	The:	0	. 1		10	Yes 2 No	3 2 P16	bably 4 □ Unknown
by	FRACTURE	OF C	-10416116		-1010	/5/	-/-					
8	MAL NUTR	101011							24a. Was	an autopsy ormed?	av	ere autopsy findings allabla prior to
ple	VIVIC NOTE	11(0)4									of	ompletion of cause death?
E									10	Yes 2 No	10	□Yas 2□No
e C	25. Was case referred to medical			,			26. Plac	a of Daat	h (Check only	one)		
To B	examiner?	Hospital:	npatiant 2 ER/	Outpatien	t 3 DO	A Oth	.00	ursing Ho		Idence 6 Ot	har /Snaci	(v)
1: 1	27. Mannar of Death	28a. Date o	of Injury 28t	. Time of		8c. Injur Wor		_ I gray I it		how injury occu		**
tlor	1. Natural 5 Pending 2 Accident Invastigation	(Monti	h, Day Year)	Injury	м		k? Yes 2.□	No				
Ca	3 Suicide 6 Could not	De Diane	of Injury - At homa,	farm. str					28f. Location	(Straet and Num	ber or Run	al Ploute Number,
T	4 ☐ Homicida datermine	buildin	ng, etc. (Specify)			,				wn, State)		
ŭ	29a. Certifier 17 Certifying P	hundalen: T- #	hant of my lineard	no dest	Annuar J	at the t	no det	nd class	and due to the	councie) and	anner en	stated
Medical Certification:	(Check only one)	hyaician: To the i miner: On the ba and mann	best of my knowled sis of examination per stated	ge, death and/or inv	estigation,	in my o	pinion, de	ath occur	red at the time,	data and place	, and due t	o the cause(s)
N N	29b. Signature and title of certifiar	and mann	or stated.		290	Licane	e number			29d. Date sign	ed (Month	Day, Year)
	N. A.A.A.				230						100	>
	11	MD					()9 V	17		1/9	1/48	
	30. Name and addrass of person who	complated cause	a of death (Item 23	a) (Type,	Print)		0	1				
	Haris Al	eem	300) E	· /Y		en	Van	, kno	y B	colhmon	W S	0 21214
State	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signatura	- Rond	2.92				,			
egistrar	OOL 1 U 1330	0	Later Later St.	1								



	1 Deced	ant'e Name	(First, Middle,	Lact		Certin	icate of	Death	2. Dete of De	Reg. No.	0 4	1202
hysician /Medical		0:	scar		d	Durp	hy	Ab City Town	Month 07	Dey 09	Year 98	3. Time of Deeth //:05 AM
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otor	DEL	4.	CECI	L	N	IIDDLE	TOWN					1 ☐ Yes 2 No
be notified be notified Director	10e. Street	et end Num	ber				Of. Zip Code			10g. Citizen of W	hat Country	?
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ar, or items 23s Examiner must by Funeral	з□и	ever Marrie	d 2 Marrie	12. Wes Deceded Armed Force 1 Dives 2 If Yes, Give Year or Date	os? □ No	If Ye	S, specify Cub	oan, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Specify:	e - American k, White, etc	•
other traumatic event, the Medical Examiner must be notified at	Elemen	(Specifitery/Second		grade completed) College (1-4		life. DO	l of work done VOT use retire	during most of w	vorking	16b. Kind of Bu		try
Col	17. Fethe	A Same (F	First, Middle, La	N?A		MIN	STER	18 Mother's N	leme (First, Middle	CHURC		
atic ever To Be		BERT	DUR					MARY			9)	
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Important: if item 27 is any injury or other tra	20a. Meth		sition Cremation 3	6714 PAR	SONS 20b. Pled cerr	6714 ce of Disposition netery, cremato	PARS on (Name of any or other pla	ONS_AVI	ENUE B	ALTO., M	D. 21 City or Town	215 , Stete
injury	-		Other (Spe	-	KI		10RIAL ime and Addre		7/14/98	BALTIN	TORE,	MARYLAND
any ir		1		THE S	T. GW	YNN	EWIS	T. GWY	NN FUNE	RAL HON		215-6393
ician dical		1. Enter the ck, or heart e Ceuse (Fi		omplications that only one cause on			~	,	IGHTS A iac or respiretory	VE BA	ALTO	MD . proximate terval Between nset and Deeth
miner	disease of resulting	r condition	4 - 62-		Due to (or e					/		25 min
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the funer cation	3 □ S	ccident	5 Pending investiga 6 Could no determine	tion t be 28e. Plece of	Day Year)		M 1	rk?]Yes 2□No		Street and Numbe	er or Rural R	oute Number,
3 =	***	Milicide			etc. (Specify)			me, dete and pla	City or To			
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lical		K Only 2	Certifying Medical Ex	Physician: To the be taminer: On the basis end manner	of examinetion	edge, death oc n end/or invest	gation, in my	opinion, death oc	curred et the time,	cause(s) and mar dete and place, e	nner as state and due to the	d. e cause(s)
	(Checone)	x only 2	Certifying Medical Ex	end manner	of examinetion	end/or investi	29c. Licens	opinion, death oc	curred et the time,	dete and place, e	ond due to the	e cause(s) v. Year)
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	719-30 01N	/	47				177	1132		MD
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ctc	MD n,	/a	ватт	imore	2					OCINE 2
-i-	10e. Street and Number			10f. Zip	Coda			10g. Citizen o	f Whet Cour	ntry?
<u>a</u>	125 Albemari	le St.			2	12 0 2		U	ISA	
Funeral Director	11. Marital Status	12. Wes Decedent Eve Armed Forces?	r In U,S. 13	3. Was Dece	dent of h	Hispanic Origin? (5 pan, Mexican, Puer	Specify Yes or N	o- 14. R	ece - Americ	
교	Never Married 2 Married	1 ☐ Yes 2 XXX			L-LL-C		to ringari, ato.,			
Completed by	3 Widowed 4 Divorced	If Yes, Give Yaer or Dates:		1 🗆 Yes	244.00	Specify:		Spec	ify: B.	lack
8	15. Decedent's Ed	fucation		cedent's Usu				16b. Kind of	Business/In	dustry
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	17. Father's Neme (First, Middle, Last)					19 Mother's No	me (First, Middle	-		
Be										
2	John J. Daver	nport				Gert	rude	Willi	ams	
	19e. Informant's Name/Reletionship (7	Type, Pnint)	19b. Ma	ailing Address	s (Street	t and Number or R	lural Route Numi	ber, City or Ton	m, Stata, Zip	Code)
	Paulette Butler	r/sister	500	2 Gov	van	Avenue	Balti	more,	MD :	21212
	20e. Method of Disposition	- 2	20b. Plece of Dis	sposition (National National N	me of	100)	Date	20c. Location	n - City or To	own, Stete
	1 Aurial 2 Crametion 3	Ramoval from Steta	Wester	1		100)	71.	2 11		11
-	4 Donetion 5 Other (Specify		Nesta	., -,		45 00	1111	Balti	more	, MD
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2 Data of Death Month **Physician** JULY 1998 0812 AM **WAMA** /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beltimore
If Undar 24 Hrs. 8. Date BeHimar Hospita If Under 1 Yaar 8. Data of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 214-44-9042 1□M 250€ Months Days Hours Yrs. Director Usual Rasidance of Decedant the Marylend 10b. County 10a. Stata 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Modical Examiner must be notified at 1 Nas 2 No Md Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? USA permit. Peges 1 end 2 should be filed within 72 hours after death w. Depertment of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or flams 23a any Injury or other traumatic event. 162 Funeral Was Dacedant Evar in U,S. Armed Forces? 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dates: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1□ Yas 2 No Specify: p 3 Widowed 4 Divorced ack Completed 15. Dacedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DQ NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Name (First, Middla, Last) Eaddy Dennie Wilhelmina 19a. Informant's Name/Relationship 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Balto. Md. 21229 20b. Place of Disposition (Nama of cematary, crematory or other place) HUSDand 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from Stata Cemetery 4 ☐ Donation 5 ☐ Other (Specify) tark 22. Name and Address of Facility

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11. Addr 21. Signature of Funaral Sarvice Licensee Approximate Interval Batwaan Onset and Death **Physician** /Medical Immediata Causa (Final vesse disease disaasa or condition rasulting in death) Examiner Lusson burial-transit Sequantially list conditions, if any, laading to immadiate causa. Enter Underlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last and Dua to (or as a consequence of). physician a the burial Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other significant, conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown TSILUNE 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of ceuse of death? Completed 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was cesa raterred to medical examinar? 26. Placa of Death (Check only ona) Hospital: 12 Xes 2 No Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding Invastigation 1 Natural 1 ☐ Yes 2 ☐ No efter death. 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Cartifiar Certifying Physician: To tha bast of my knowledga, daath occurred at tha tima, data and place, and due to tha causa(s) and manner as stated. (Check only one) 2 Madical Com r: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29d. Data signed (Month, Day, Year)

SKIM

32. Registrar & signature

Filma Davidson - Fandara

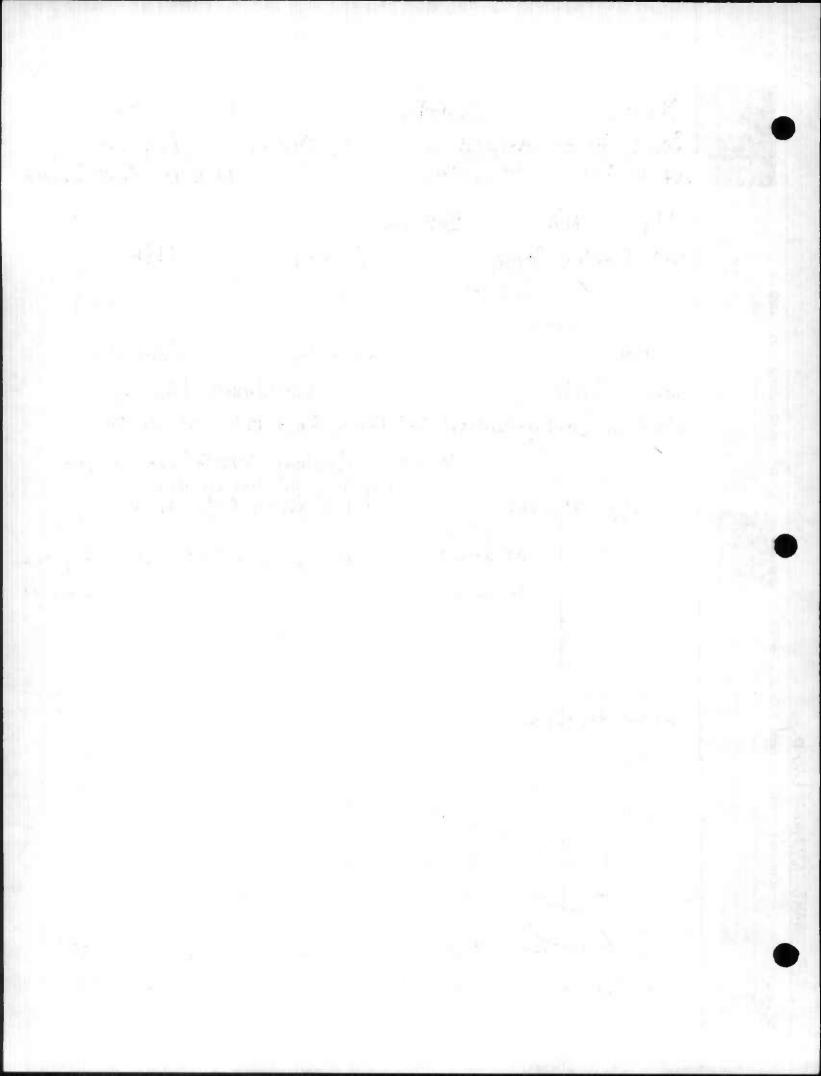
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south Calon Avenue, Buttomere

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

Registrar

29b. Signatura and title of certifian



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 4b. City, Town, or Location of Death Baltimore Month SEAN 715AM 4a. Facility Name (If not institution, give street and number) 4c. County of Death Good Samaritan Hospital 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) Days 1 □ M 2√2 F 80 189-16-4549 Yrs Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4211 Springwood Avenue 21206

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuben, Mexican, Puerto Rican, etc.) U . S. A. Hace - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No
If Yes, Give X
Yeer or Dates: 1 Yes 2 No Specify: SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Adam Wojtukiewicz Hieronima Kizielewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Louis E. Dorer 4211 Springwood Avenue Baltimore, Maryland 21206 of Disposition (Neme of Date 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 7/11/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Dippel Funeral Home Inc. 21. Signet of Funeral Service Licensee Thomas Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Maryland 21206 shock, by heart failure. List only one cause on each line. Onset end Death Immediate Ceuse (Final disease or condition resulting in death) a Micandial Infanction Due to (or as e consequence of): Car DioGenie Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Carida Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes No No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ₹No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Natural 2 Accident 5 Pending investigation

1 ☐ Yes 2 ☐ No

Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medicai Examiner

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Certification:

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Examiner

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rai", or items 23a or 28a-f ehov Examiner must be notified at

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Pages 1 and 2 should be filed within 72 hours effer death with the Maryland nent of Health and Mental Hygiene. In: If Rem 27 is marked other than "natural", or items 23a or 28a-f ehow

other than "natur

Item 27 other t

permit. Pages Department of Important: If it any injury or o

Baltimore, Maryland 21215-0020

physician end the burial-transit 60 use signed by the a

requires that the death certificate be executed Vital Records, P.O. Box 68760,

24 hours To the Hosp within 24 ho To the Fune completely fi

State

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print) Adriava Avanual Good Samanitar Haspital 5601 Loch Rover Blud 21239, 2995 31. Dete filed (Month, Day, Year)

29b. Signeture end title of certifier

6 Could not be

Adriance Andred MD

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

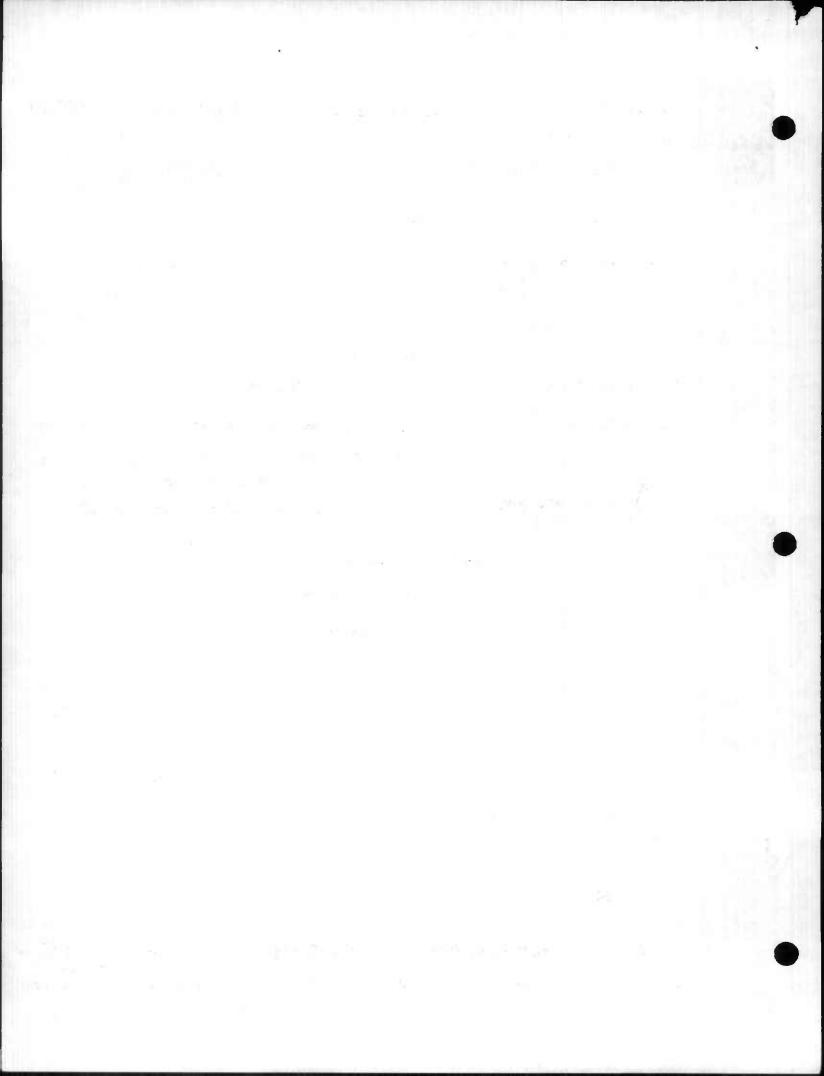
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3 Suicide

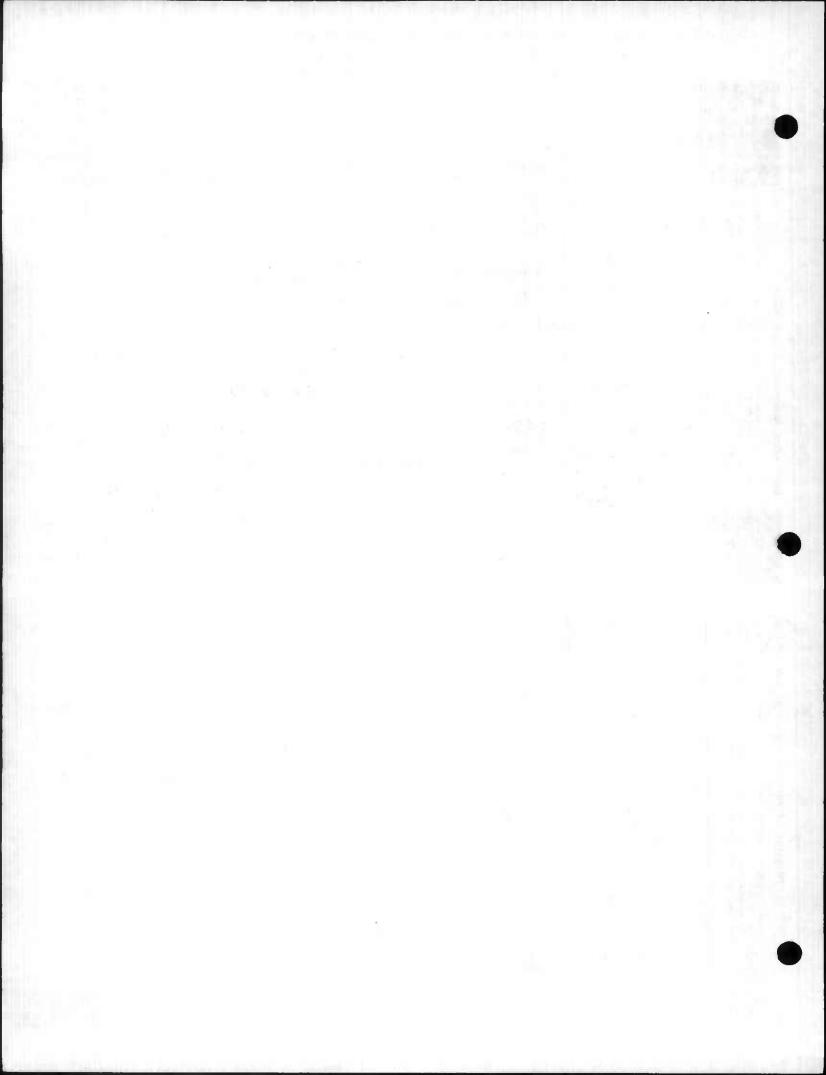
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ā	2 she end ls m		19a. Informant's Name/Relation	ship (Typ	pe, Print)		19b.	Meiling Add	iress (Street	and Numb	er or Rura	Route Numb	er, City or Town	n, State, Zip	Code)	
	and aalth n 27		DONNA M. DIORGI	E / I	DAUGHT		45	02 AR	ABIA A	VE F	BALTII	MORE.	MD 2121	4		
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a	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Menylan Department of Haalth end Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23e or 28s-4 show withingty or other traumatic event, the Medical Examiner inval by notified at ODEs.		21. Signature of Funeral Service	e License	160			22. Nam	e end Addre	ss of Facili	lv					47777
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Division of Vital	Attending Physician: The law ir death. ector: After this certificate hes E by the funeral director, page 2 s	To Be	examiner? 1 ☐ Yes 2 🖽 No		ospital: 4 50	Inpatient 2		petient 3[DOA Oth	oer.		(Check only	dence 6 □O	than (Chaoibi		
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É	efte Dire	Certification:	4 Homicide		build	ling, etc. (Spe	cify)		,			City or To	wn, State)			
	spita nours neral		29a. Certifier 1 Certify	ing Physi	ician: To the	e best of my ki	nowledge,	deeth occur	rred et the tir	me, dete an	d placa, e	nd due to the	ceuse(s) and n	nenner as sta	ited.	
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fo	edicai	(Check only 2 Medica one)	Examin	ar: On the b	pasis of axamin	nation and	Vor investiga	ition, in my o	plnion, dea	th occurre	d at the time,	date end plece	, and due to	the ceusa(s	1)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** THOMAS DOCHERTY 8: 45 PM JUL 1998 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Hospital Co Center tranklin Square 16. Sex Rosedale Raltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number Birthpiaca (State or Foreign Country) **Funeral** Months 1 **X** M 2 □ F Days Director 329-05-8197 Illinois Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. inside City Limits r 28a-f show 10a Stete 10b. County 1 ☐ Yas 2 ☑ No Baltimore Director Maryland Middle River 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours after death with it and Mental Hygiene.
7 is marked other than "natural", or items 23a or : traumstic avent, the Modical Examine (mest be to traumetic avent, the Modical Examine (mest be a US Henderson Road 21220 A 30 Funeral 14. Race - Amarican Indien. 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status Black, White, etc. 1 ☐ Yas 2 ☐XNo If Yes, Give Yaer or Dates: 1 Navar Married 2 17 Married 1 ☐ Yas 2 XNo Specify: Specify: White py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Forklift Operator 8th Grade Crown, Cork, and Seal 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Pagas 1 and 2 should be f nent of Haalth and Mental ? Brown Marguerette Thomas Docherty 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MD 21220 30 Henderson Road Baltimore, Lillian M. Docherty / wife Hem 20b. Pleca of Disposition (Neme of cematary, crametory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition permit. Pagas Department of Important: If it any injury or c 1 □ Burial 2 💆 Cremetion 3 □ Removel from Stete Metro Crematory 7/8/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Address of Fecility 21. Signatura of Funerai Service Licensee Connelly Funeral Home of Essex 300 Mace Avenue Baltimore, and of the mode of dylng, such as cardiac or respiratory errest, Maryland 21221 23a. Pert1. Enter the disease, or complications that caused the death shock, or hear failure. List only or cause on each line. m Approximete Intervel Between Onsat and Death **Physician** immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner tivefulmonary Examiner hronic notin and bunal-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 62760 Physician/Medical Due to (or es a consequenca of) usa Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings avelleble prior to complation of causa of deeth? 24e. Wes an eutopsy performed? Completed cartificate hes b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funaral director. 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Neturel 2 Accident 5 Pending 1 Yes 2 No death. investigation after deat n 24 hours after dec Ne Funeral Director oletaly filled in by the 6 Could not be Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 29a. Certifier Medicai To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licensa number Jamore, MD

ho completed cause of deeth (Item 23e) (Type, Print)

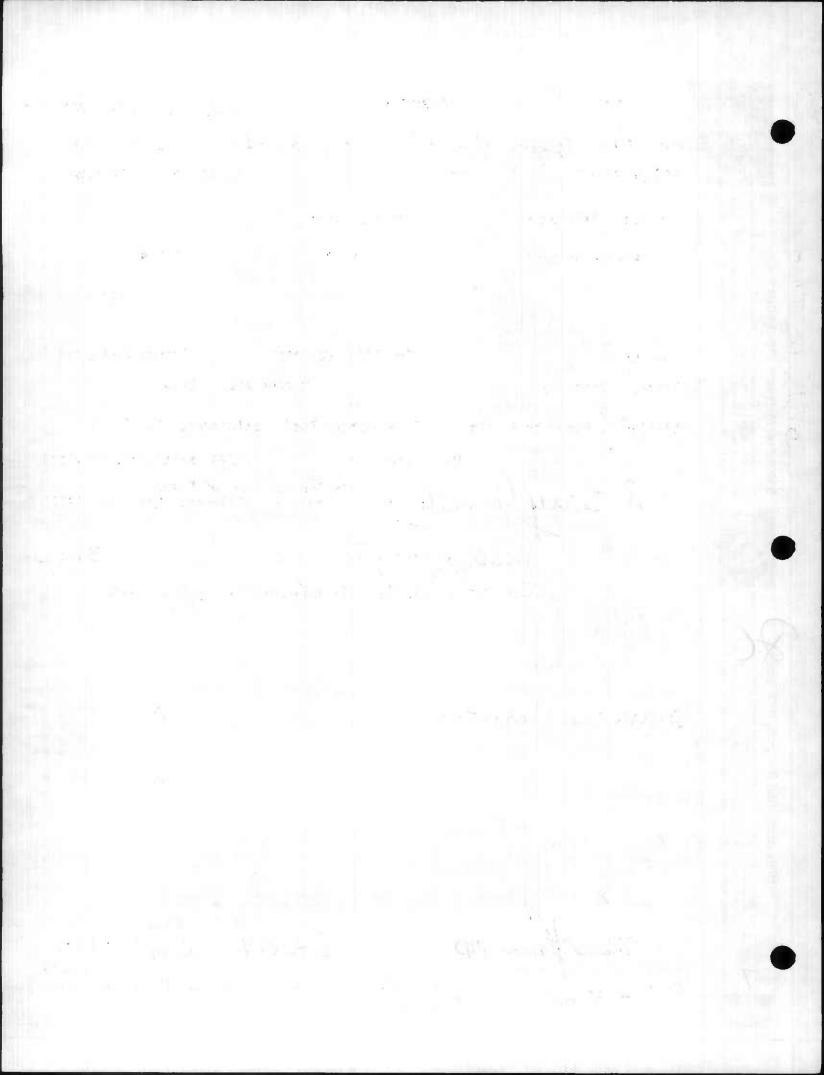
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Franklin Square Drive

State Registrar 30. Name and address of person

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Cecelia A. Edwards 1998 4:25 PM July 4e Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death ROCKVITIF M If Under 24 Hrs. Hours Min. B. Date of Birth (Month, Day, Year) SHADY GROVE ADVENTIST HOSPITAL MONTGOME RY 9. Birthplace (State or Foreign Country) Months Days 1□ M 2□F 74 235-34-1799 August 4,1923 West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Maryland Bowie Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20715 12431 Starlight Lane 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□Yes 2□No If Yes, Give Year or Detes: Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ruth McMurrer James J. Hoban 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) 19a. Informant's Name/Reletionship (Type, Print) 12608 Falconbridge Dr. Gaithersburg, MD Mary Ann Moore/daughter 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/11/1998 4 ☐ Donation 5 ☐ Other (Specify) Clinton Resurrection Cemetery 21 Sinne Tre of Funeral Service Licensee 22. Name end Address of Facility Robert E. Evans Funeral Home Inc. 20715 Bowie, MD 16000 Annapolis Rd. in 1/Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NON HODG-KIN'S LYMPhomA Due to (or as a consequence of): MONTA disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Typentension

Physician /Medical Examiner

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Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite

Maryland 21215-0020

altimore,

Division of Vital Records, P.O.

with the Maryland

death

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Physician/Medical 987

24a. Was an autopsy

24b. Were autopsy findings evelleble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No.

25. Was case referred to medical examiner? 1 Yes 2 No

1 Inpatient 2D∈R/Outpatient 3D DOA 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Center Drive Lockville

1 Tyes

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, sfreet, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29th Signature and pair of cedition

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar DAVID SROUR M.D. JUL 1 0 1998

33 Tame and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical 32. Registrar's Signature

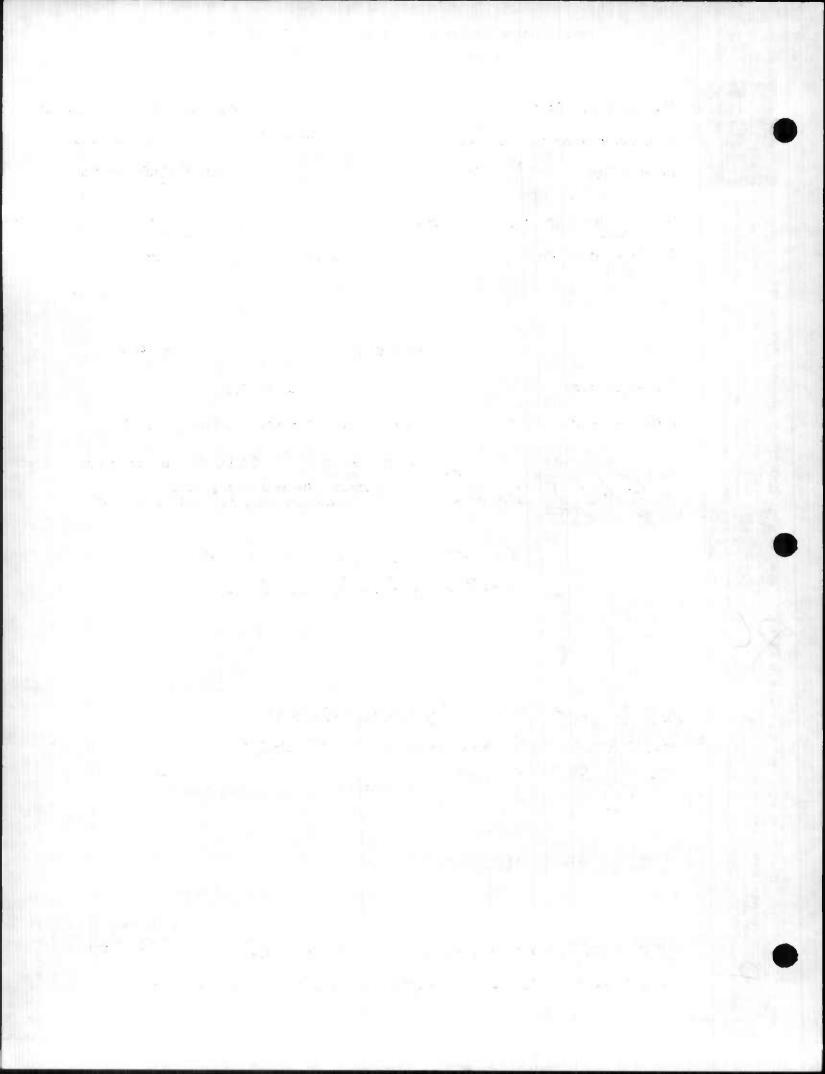
Julia Davidson Pandall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

						inal ylai	Ce	rtificate of	Death		Reg. No. 9	3 2	1209
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E	Funeral Director	212-	50-9466	6. Sex 1 ☐ M	XXF 7.	Age (In yrs. 89	last birthday) Yrs.	Months Deys		8. Dete of Bir (Month, Da March	y, Year) 23,1909	9. Birthple Count Mary	ace (State or Foreign ry) rland
	how	10a. State	ence of Decedent 10b. Cour	nty		10c. Cit	ty, Town or Lo	ocation				10	od. Inside City Limits
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Registrar



State of Maryland / Department of Health and Mental Hygiene Q 2 2 1 2 1

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	dical niner	4a Facility Name (If not institution,	giva street end number)				4b. City, To	wn, or Lo	cation of Deeth	4c. County	of Dealt	1	
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and 21215-0020 be filed within 72 hours after death with the Manyland all Hygiene. d other than "natural", or frams 23a or 28-4 show event, fre leaders and the second and the second are second.	by	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Dacedant E Armed Forces? d 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas:		If Yes, spec		Ilspanic Ori an, Mexicar Specify:	gin? (Spi n, Puerto	ecify Yes or No- Rican, atc.)	Bla	ck, White		
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Physicia	ın	23a. Part1 Enter the disease, or o shoot, or heart failure. List o	plications that caused one cause on each line	the death. Do not e	enter the mod	e of dyl	ng, such es	cardlec	or respiretory arre	est,	aryı	Approximate Interval Bette Onsat and I	e ween
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yaich yaich greed	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 XER/Outpat	lent 3 DC	A Ott	her: 4 N	ursing Ho	me 5 Resida	nca 6 □Ot	her (Spec	cify)	
Division of Vita ior Attanding Physician: after death. Director: After this cardific in by the funeral director,		27. Manner of Deeth 13☑ Natural 5 ☐ Pending 2 ☐ Accident invastigs	28e. Date of Injun (Month, Day	Year) 28b. Time Injury	of 2	8c. Inju Wo 1 □	ryal rk?]Yes 2 □	No	28d. Describe ho	w injury occu	rred		
그 오른 것 드	Certification:	3 ☐ Sulcide 6 ☐ Could no 4 ☐ Homicide determin	of be ed 28e. Pleca of fnju- building, etc.	ry - At home, farm, (Specify)	street, fectory	, offica			28f. Location (St. City or Town	reet and Num , Stete)	ber or Ru	rai Route Num	ber,
Hospital 24 hours Funeral staly filled	edical C		Physician: To the best of caminer: On the basis of and manner state	axamination and/or									i)
within to the To the comple	Me	29b. Signature and title of pertition			290	. Lican:	sa number		25	9d. Dete sign	ed (Monti	h, Day, Year)	
- > + 0	0	> la O. Er	m 100			D4	2729			July	9,19	98	
3	J	30. Name and address of person w	no completed cause of de ID 8817 Bela			20	5 Balt	timo	re, Mary	land 2	1236		
Regi	State strar	31. Date filed (Month, Day, Year)		r's Signature A Hawldoon—I	junaca								

DHMH 16 Rev 6/95

1958 F S S ASS OF THE SECOND Manager Control of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 92709c CO AND JUL 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE AUNES HOSPITAL 6. Sex 12 M 2□ F If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign 219-07-2316 Yrs. Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 100 es 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2725 2121 Was Decedant Evar in U.S. Armed Forces? 1 Zoras 2 No 42 - Vear or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Nevar Married 2 Married 1□ Yes 2 No Specify: Specify: 1ac 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Sedondary (0-12) Coilege (1-4or 5+) 17. Father's Name (First, Middle, Last). 18. Mother's Name (First, Middle, Maiden Sumame) 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Darlene 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State FOREST 4 ☐ Donation 5 ☐ Other (Speelfy) 21. Signature of Funeral Service Licenses Part I Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. 02/2/ Approximate Interval Between Onset and Death Immediate Cause (Final disaasa or condition resulting in death) PNEUMONIA 3 DAYS Due to (or as a consequence of): DASTRUCTIVE PULMUNART DISEASE 10 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that leithed execute.) Due to (or as a consequence of): 4 WEEKS BACTERIAL ENDOCARDITIS that Initiated events resulting In death) Last Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHRONIC RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CONGESTIVE HEART FAILURE 1 Yas 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 27 Manner of Death 28c. fnjury at Work? 28d. Describe how Injury occurred 1 Matural 5 Pending investigation 1 Yas 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Placa of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Thomicide

JUNIOR 9 FORGE E PIPS,

Physician

/Medical

Examiner

Director

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Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at

Department of Health and Mental Hygiene.
Important if fee if merked other than "natural any injury or other traumatic even."

Physician /Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification:

29a. Certifier (Check only one)

with the Maryland

Director: After death or A after To the Hospital within 24 hours a To the Funeral (

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier MD.

29c. Licensa number P10873 29d. Date signed (Month, Day, Year)

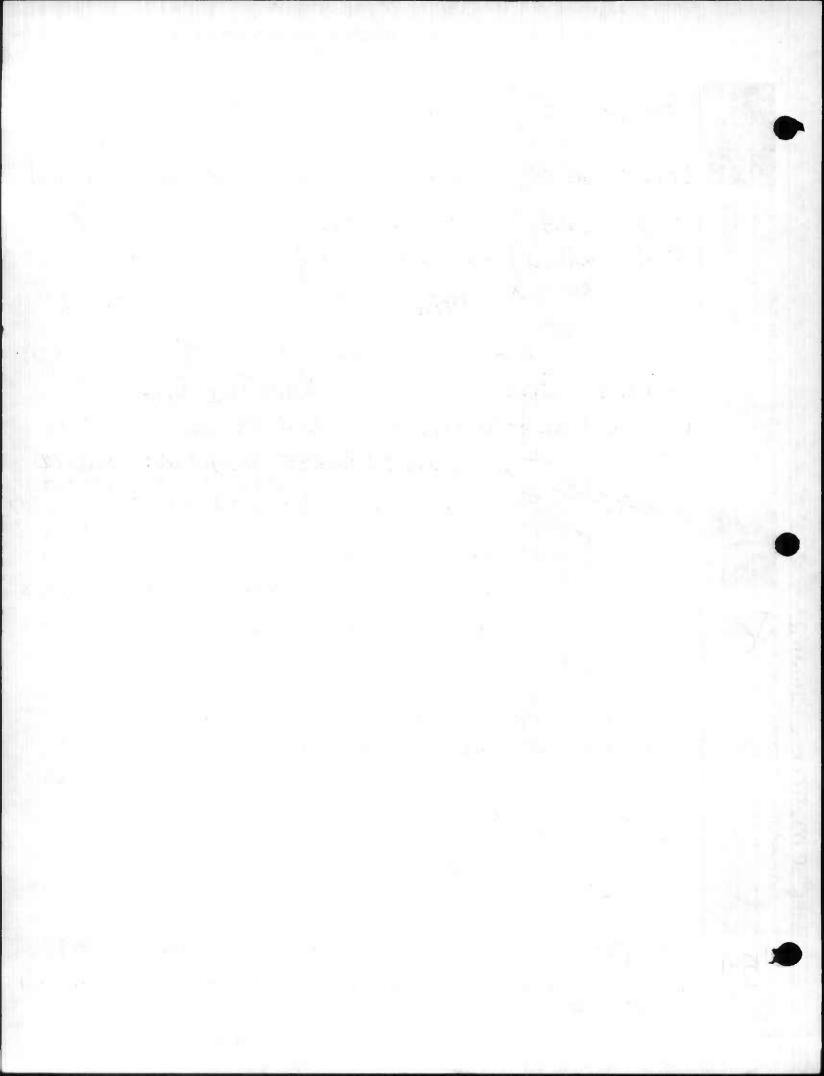
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1998

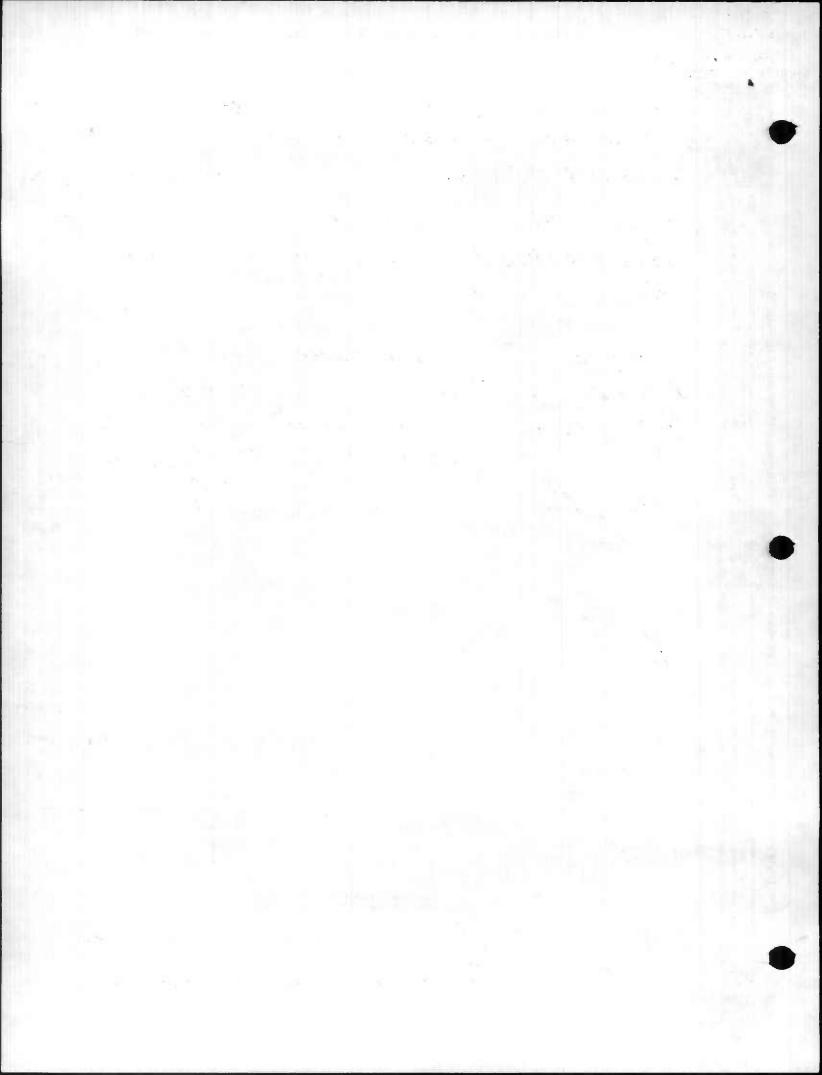
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST AGNES HOSPITAL, SOO CATEN AVENUE, BALLIMORE, MD, 21229 FRANCIS BUADI

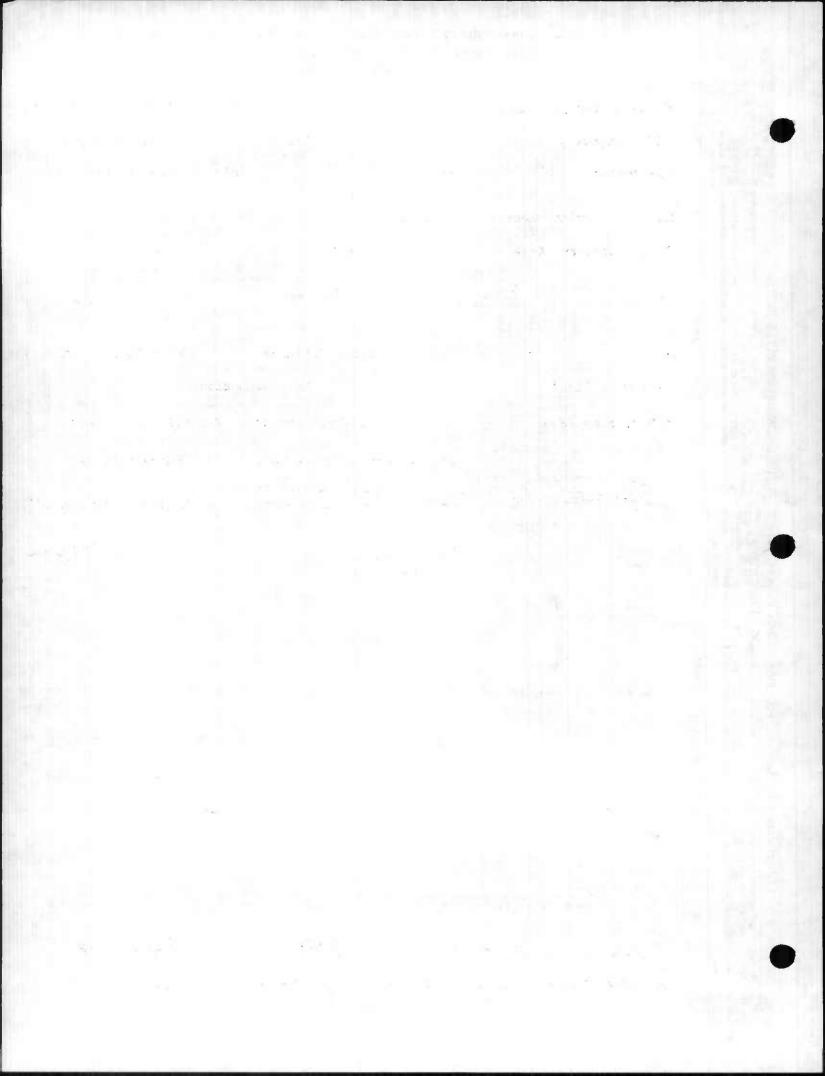
32 Registrar's Signature The Davidson Bands 00



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UNK	NOWN ,98-	State of Maryland / Department of Health and M	lental Hygi	iene	
RHONDA	J. FOWLE	ESITEMS: #23 PART I, 27, 28A-F PER ME FILM Certificate of Death	Re	eg. No.	18 21212
,	Dharistan	1. Decedent's Neme (First, Middle, Last)	2. Dete of Deetl Month	h Dav	3. Time of Death
120	Physician /Medical	RhONDA JAMEHE FOULKES	JUNE 2	29, 1998	12:50 PM
	Examiner	4e Facility Name (If not institution, give street end number) 4b. City, Town, or Lo		4c. County	of Death
		3529 SOUTH HANOVER STREET - IN REAR ALLEY BALTIMOR		1	14
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 1 Under 1 Year 1 Under 24 Hrs. Months Deys Hours Min.	8. Dete of Birth (Month, Dey,	Year) ICar -	Birthplece (State or Foreign Country)
	Director	Usual Residence of Decedent	JUME 1	6176	Marylono
	show rd.at	10a. Stete 10b. County 10c. City, Town or Location		-	10d. Inside City Limits
	the Meryla r 28a-f show notified at	Manulan N/A BAITIMUR			1 No 2 No
-	or 284 or 284 Or ec	10e. Street and Number 10f. Zip Code	10	0g. Citizen of W	/hat Country?
	fier death with the Me ritems 23s or 28s-1s wher must be notified Funeral Director	4225 OND FREDERICK LOAD 21229		U5.	n
	kems in the mer mer mer mer mer mer mer mer mer me	11. Merital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerto	ecify Yes or No-		- American Indian, k, White, etc.
0	or he man	1.2 Never Married 2 Married 1 Yes 2 No If Yes. Give 1 Yes 2 No Specify:		Specify	: 0/ /
00	ural', o	3 Widowed 4 Divorced Year or Dates:			Black
5	"nath	15. Decedant's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use ratired)	ing	16b. Kind of Bu	
21215-0020	filed within 72 hours after death with the Meryland Hygiene. Physione. Port the Medical Examiner must be notified at Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4or 5+)	135-15	OUN 1	Yonc
0	be filed with ntel Hygiene. od other ther event, the Be Be Comp	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, N	Aaiden Sumem	e)
la la	T S S S T	BUBBLE HENDERSON-FUW/KES ROBER	ta Ex	05	
Maryland	d 2 should be ith end Mentel it is marked of traumatic eve	19a. Informany's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Straat end Number or Run		City or Town	Steta, Zip Code)
	2 2 2 2	BORBY H. FOWKES 727 Scot St KO	SLSPAY	nt PA	17834
Ψ.	8 5 T	20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place)	Date 7-90	20c. Location -	City or Town, State
Ĕ.	Pag nent nent: I	4 Donetion 5 Other (Specify)	7-70	BMM	40KE, Ild
alt	permit. Departr Importu any inju	21. Signeture of Funerel Service Lieurisee 22. Name end Address of Fecility	VATMA	x- NAY	exis F./1.
ш	80558	Baiding Baiding of Ha	2/2/	15	
100		23a. Part. Enter the Assess, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock or heart failura. List only one cause on each line.	or respiratory erre	est,	Approximete Interval Between
	hysician				Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition rasulting in death) a. COCAINE AND NARCOTIC INTOXICATION			
100	<u> </u>	Dua to (or as a consequenca of):			
	exacuted n end iel-transit Examiner	b			
		Sequentially list conditions, if any, laading to immediate cause. Enter Underlying			
		Cause (Disaese or injury that initiated events			
89	certificate be nding physicia use es the bur n/M edical	resulting in death) Last			
Вох		d			
. E	he ette hed for sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld to	bacco use cor	ntributa to the cause of death?
P.O	d by detect		1 □ Y	es 2□ No	3 Probably 4 DUnknown
Sp.	v requires that the de been signed by the should be deteched leted by Physic		04-144		24b. Wara sutopsy findings
0.0	been should		24a. Was a perform		evailable prior to completion of cause
3ec	the law require the sate has been single 2 should Completed		4		of death?
				as 2 No	1 Yas 2 No
of Vital Records,	ysicien: s certific director, fo Be	25. Was casa rafarred to medical examiner? 1 M Yes 2 No 1 No point 1 no patient 2 ER/Outpatient 3 DOA Other: 4 Norsing Ho			er (Specify) AT SCENE
Jo .	6 6	27. Mannar of Death 28a. Dete of Injury 28b. Time of D 28c. Injury st	28d. Describe ho		
Division	death. ctor: After y the fune ifcation	1 Natural 5 Pending (Month, Dey Year) Injury P Work? 2 Accident investigation FOUND 6-29-98 FOUND 12.50	UNKNOWI	N	
Vis	or de or de by th	3 Suicide 6 Could not be datarmined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St.	reet end Numb	er or Rural Route Number, 9 HANOVER ST.
	tal or Attending Progression of Attending Progression of Attending Progression of Attending Certification:	FOUND IN REAR ALLEY	BALTIMORE		
and and and and and and and and and and	to the regulate or seriends within 24 hours eiter death. To the Funeral Director: A completely filled in by the tame of the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the foll	29a. Cartifiar (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch	end dua to tha ce	eusa(s) and ma	nner as stated.
	The F	one) and manner introd.			
5	To the	29b. Signeture end tille of certifier 29c. License number O.C.M.E	2		d (Month, Dey, Year)
	1-			30111 3	0, 1000
	5	30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)	wo Marr	·land o	1201
	0	31. Date (ijed (Month, Day, Year) 32. Registrar's Signature	re, mary	y Land 2	1201
1/1	State Registrar	31. Date filed (Month, Pax, Year) 1998 32. Registrar's Signature			



		Certific	ate of	Death		Reg. No.	0 41	Cime of Death
1. Decedent's Name (First, Middle, La					2. Dete of De Month	Day	Yeer	
Kenneth George 4a Facility Neme (If not institution, giv	Flood e street end number)			4b. City, Town, or I	July ocation of Deat		_	30 p.m.
335 Montgomery S				Laurel			ce Geor	ge
5. Sociel Security Number 6. S	ex 7. Age (In yrs.	last birthdey) If U	nder 1 Yeer	if Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De	v. Year)	9. Birthplece (S	Stete or Foreign
202-10-0300	71 71	Yrs.	and Days	1,00.0	July 10	1,1926	Pennsyl	vania
Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location					10d. In:	side City Limits
MD Prince	George L	aurel					15	Yes 2□ No
10e. Street and Number		10f	. Zip Code			10g. Citizen of V	Whet Country?	
335 Montgomery S	treet		20707			USA		
11. Maritai Stetus	12. Was Decedent Ever in U. Agned Forces?	S. 13. Was D	ecedent of h	dispenic Origin? (S an, Mexicen, Puert	pecify Yes or No	- 14. Rec	e - Americen Ind ck, White, etc.	Jian,
1 Never Merried 2 Married	1 X Yes 2 No If Yes, Give		s 2X No			Specify		0
3 ∰ Widowed 4 □ Divorced	Year or Dates:	160 Decedential	Javal Onour	nation		16h Kind of R	usiness/industry	
15. Decedent's Ed (Specify only highest gra	de completed)	16e. Decedent's (Give kind o	f work done T use retire	during most of word)	king	100. Killu Ol Di	usiness/industry	
Elementary/Secondary (0-12)	Coilege (1-4or 5+)	Electric				Johns H	opkins	Universi
17. Fether's Neme (First, Middle, Last)				18. Mother's Nen	ne (First, Middle			
William E. Flood				Mary E.	Lanious	3		
19a. Informant's Name/Relationship (end Number or Ru)
Richard Flood/Son				Lancast				
20a. Method of Disposition 1 ☐ Buriei 2 ☐ Cremetion 3 ☐	Hemover from State	lace of Disposition emetery, cremetory		1	Date		City or Town, S	
4 Donetion 5 Other (Specif		Anthony			7/7/98	Lancas	ter, PA	
21. Signature of Funeral Service Liver		17.1	1- 17	ess of Fecility Ineral Ho	me, Inc	•		
Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	76	01 Sar	ndy Sprin	g Road,	Laurel,	Maryla	nd_20707
shock, or heart failure. List only	one cause on each line.	i. Do not antar the	mode or dyn	ng, such es cardiac	or respiratory e	111001,	Inten	val Between et end Deeth
Immediete Cause (Finel	5.	shysem.	21				> >	54ense
disease or condition resulting in deeth)	0.	r es a consequence				-		
	_	21						
Sequentially list conditions,	Due to (o	r es a consequence	of):					
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	c							
resulting in death) Last	Due to (o	r as a consequence	of):				1	
	d							
Pert II. Other significant conditions of	ontributing to death but not res	ulting in the underly	no cause oi	ven in Part I.	23b. Did	tobacco usa co	ntributs to the	csuss of death?
•	•				1 🗆	Yss 2 No	3 Probably	4 Unknown
							1	
						s en eutopsy ormed?	aveilable	utopsy findings e prior to tion of cause
					7		of death	?
					10	Yes 2 No	1 ☐ Yes	2 No
25. Was cese referred to medical examiner?	Hospital:		Ott	26. Piace of De				
1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 ☐	ER/Outpatient 3L 28b. Time of	DUA	4 Li Nursing F		how Injury occur		
1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey Year)	Injury M	28c. Inju Wo	rk?]Yes 2∐No				
3 Sulcide 6 Could not b	e 28e. Place of Injury - At he building, etc. (Specif	ome, ferm, street, fa	ctory, offica			(Street end Numi	ber or Rurel Rou	ite Number,
4 Homicide	building, etc. (Specif	Y)			Ony or re	iwii, State)		
	ysician: To the best of my kno niner: On the basis of examina	wiedge, deeth occu	rred at the ti	ime, date and place	, and due to the	ceuse(s) end m	anner es stated.	cause(s)
29a. Certifier 1 Cartifying Ph	and manner steted.							
(Check only 2 Medical Exar	and manner steteo.					∠yu. Date signe	ed (Month, Dey,	i eai/
(Check only 2 Medical Exar	and marrier steteo.		29c. Licen.	Se number		1.1.	2 1000	
29b. Signature end title of certifier Andrew Ku	ueden MD		\$3	16/16		July :	2,1998	
(Check only 2 Medical Exar	completed course of death (Item	n 23a) (Type, Print)	\$3	18716 Ldne	(Au-	July :	2,1998	



Physician /Medical **Examiner**

Funeral Director

Directo

Funeral

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Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examine must be notified anonce.

Physician

/Medical

Examiner

been signed by the attending physician and should be detached for usa as the bunel-transit

certificata has b lirector, page 2 s

After this

Director:

death.

200

illed in by the funeral

The law requires that the death certificate be axecuted

Attending Physician:

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

à

Completed

Be

Medical Certification: To

Baltimore, Maryland 21215-0020

FRANKLIN	Pleas	e Type or State of		nt in Biac aryland / I	Depa	rtmen	t of I		and M	fental Hy		gible.	21214
n. Decedent's Nar Charles			nkl	in				2		2. Date of De Month		Year B	3. Time of Death 0024 AM
le Fecility Neme 1822 WI	(If not institution, LHELM ST		ım <i>ber)</i>					4b. City, To BALT		ocation of Deetl		ty of Death	
	6. Sex 7. Age (In yrs. lest birthdey) 1 1 1 1 1 1 1 1 1						1 Year Deys	-	24 Hrs. Min.	8. Date of Bir (Month, Da 05 – 05			nplace (State or Foreign untry) Yland
Jsual Residence	of Decadent												
Md .	10b. County Balti	more		Balti									10d. Inside City Limits 1 Yes 2 No
1822 V	umber √i1helm	Stree	t			10f. Zip	Code 223				U.S.A		untry?
11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent Ever in U,S. Armed Forces? 11. Was 2 (34)					13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes XIXNo Specify: 1□ Yes XIXNo Specify: Specify: Whi				etc.				

15. Decedent's Education (Specify only highast grada complated) Elementery/Secondery (0-12) College (1-4or 5+)

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Janitorial Services

17. Father's Name (First, Middla, Last) Howard Franklin

Retail Clothing 18. Mother's Name (First, Middle, Meiden Surnama)

19a. Informant's Name/Relationship (Type, Print)

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

Mary Blockinger

Lillian McCubbin - Sister 20a. Method of Disposition

1822 Wilhelm Street, Balto., Md. 21223 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Date 20c. Location - City or Town, State Inc-6-98 Baltimore, Md.

1 Burlal 2XX remation 3 Removel from State
4 Denation 5 Other (Specify) 21. Service Licensee

Metro Creamatory, Ambrose Funeral Home, 22. Name and Address of Facility

MO0535

1328 Sulphur Spring Rd. Arbutus,

11. Enter the disease, or commications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, lock, or heart failure. List oply one cause on each line. Immediate Cause (Final disease or condition resulting in deeth)

Approximate Interval Between Onset and Death

Infanct of Small Intestine
Due (or as a consequence of):

(Strangulation) Umbilica Hernia

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or es e consequenca of)

Pert II. Other eignificant conditions contributing	ng to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death?

1 Yee 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No

25.	Wes case		to	medica
	examiner?			
	1 TY Wes	2 No		

Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only ona)

Other: 4 ☐ Nursing Home 5 Aesidence 6 ☐ Other (Specify)

27. Manner of Death 1 Natural

5 Pending invastigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and MTe, of cartifier

29c. License number O.C.M.E.

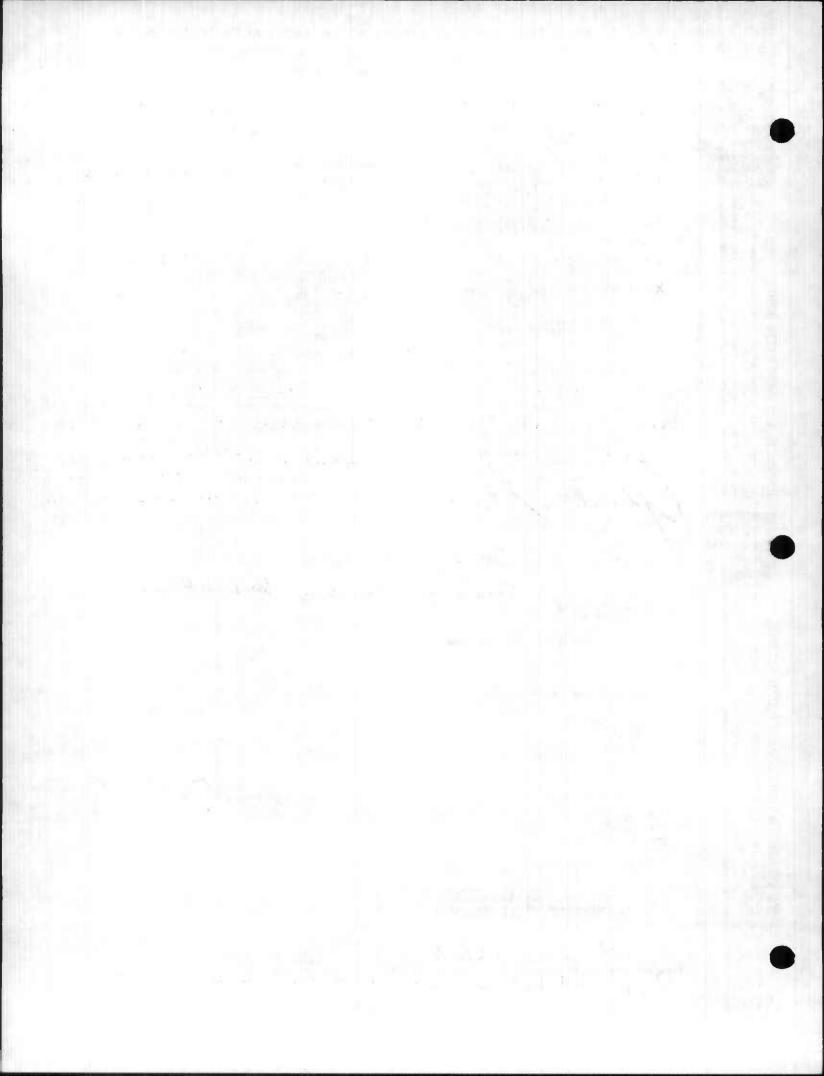
29d. Date signed (Month, Day, Year) JULY 3, 1998

281. Location (Streat end Number or Rural Routa Number, City or Town, State)

30 Name and address of person who completed cause of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

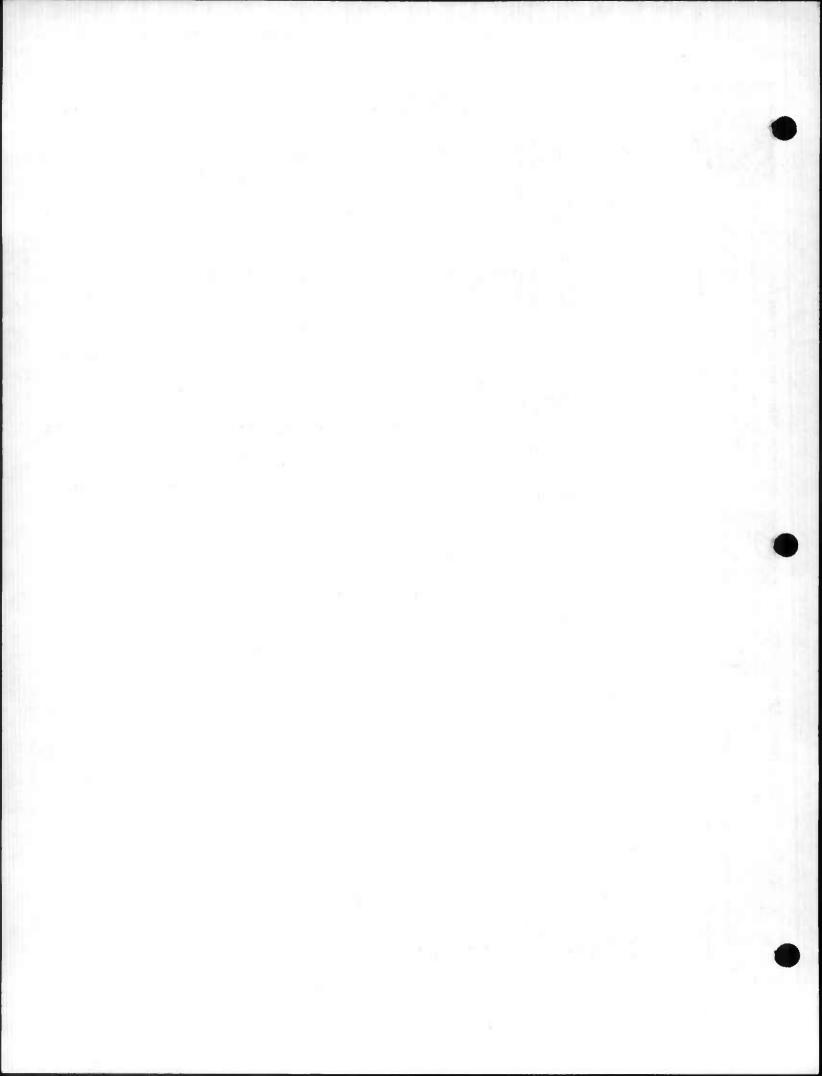
State Registrar

te MD 32. Registrat's Signature



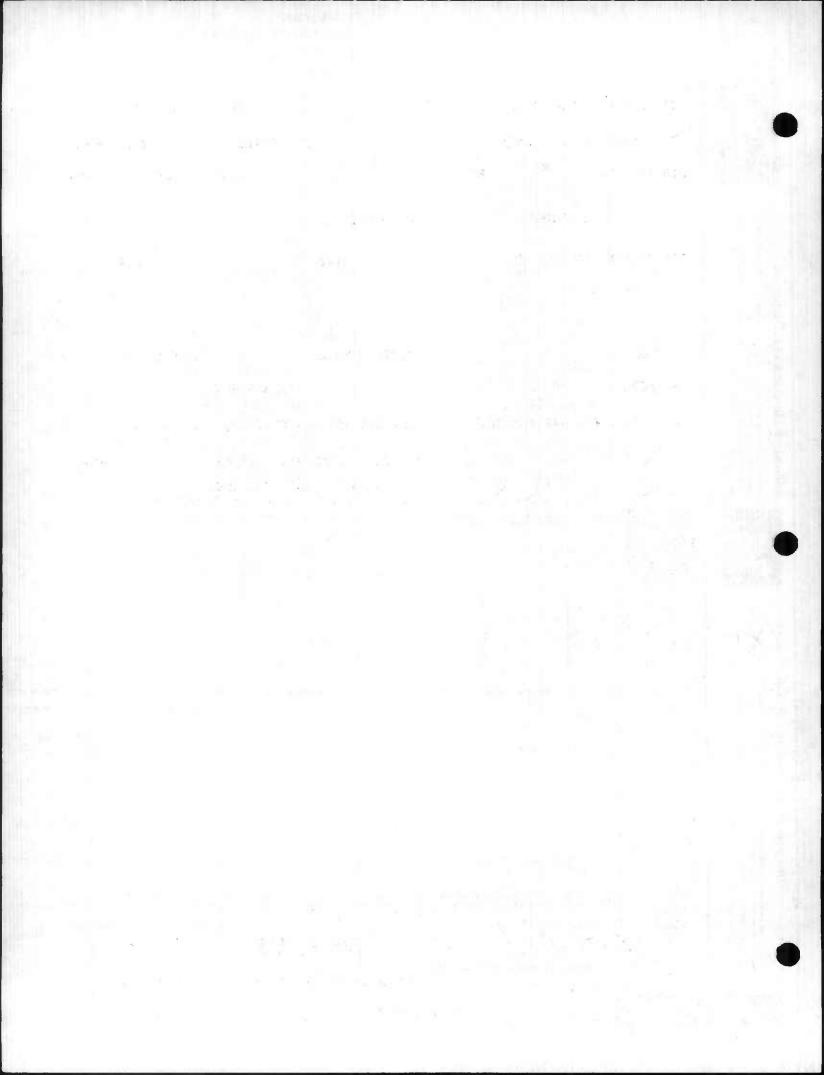
				State of Maryla		rtment tificate				giene Reg. No.	8 21	215		
	Physici /Medic				Patrick French						Year	ima of Death:		
	Examir Funeral Director		the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the c									State or Foreign		
	and and	ctor	Usuel Residence of Decedent 10e. Steta 10b. County	10c. C	lity, Town or Loc	ation						side City Limits		
	rith the Maryland or 28a-f show		MD Howard Ellicott City 1□Yes X□No											
	vith the	Director	10e. Street end Number			10g. Citizen of V	Whet Country?							
Saltimore, Maryland 21215-0020	heath w	Funeral	4617 Roundhill	2. Was Decedent Ever in	U,S. 13. W	as Decede	ent of Hisp	-6732 enic Origin? (Si	pecify Yes or No	USA - 14. Rec	e - American inc	dien,		
	within 72 hours after death with the Maryland ens than "naturel", or flems 23s or 28s-f show the Medical Examiner must be notified at	þ	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forcas? 1X Yes 2 No If Yes, Give WW Yeer or Dates:	if	Yes, specif	fy Cuban,	Mexican, Puèrt Specify:	o Rican, atc.)	Specify	ck, White, etc. White	e		
	in 72 hours	Completed	15. Decedent's Educ (Specify only highest grede	completed)	16a. Decede (Give k	ent's Usuel ind of work O NOT use	Occupetion during retired)	on ing most of wor	king	16b. Kind of Bu	usiness/Industry			
	e filed withir al Hygiena.	Сощ	Elementery/Secondery (0-12) College (1-4or 5+) Supervisor 17. Fether's Neme (First, Middle, Last) 18. Mother's Na							Soap Manufacturing (First, Middle, Maiden Sumeme)				
	lid be f fental I ked of ic eve	To Be	Arthur Pat	rick Frenc	eh		"		ian Gr					
	2 shou end M Is mer		19e. Informent's Name/Relationship (Typ	e, Print)	19b. Meiling	Addrass ((Street en		ural Route Number, City or Town, Steta, Zip Coda)					
	pemit. Pages 1 end 2 should be filed will Department of health end Mental Hygiens Important: If item 27 is marked other than eny injury or other treumstic event, the once.		Patricia D. French 20e. Method of Disposition 1 Dayriei 2 Ocremetion 3 DRe	20b.	cemetery, crem	etory or oth	ner piece)		licott	City MI 20c. Location -	21043- City or Town, S	6732		
			4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funerai Service-License	M	letro Cr						imore,			
מ	Depari Impor		Dawn F. McDo	ne Smald		rema	tion	i Soci	ety of Rd. Bal	Maryla ltimore	and, In	nc. 21228		
Ų	Physician /Medical Examiner		23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth											
			Immediate Ceuse (Finel disease or condition e. Alzheimer's Disease resulting in deeth) a.											
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	an and niel-transit	Examiner	Sequentially list conditions, literal projects Due to (or es e consequence of):											
	The Purity	edicai	Ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Dua to (or as a consaquanca of):											
XOD	Tend Tend	Physician/M	d.	-										
	tha death y the etter ached for u		Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i.							tobacco use contribute to the cause of death?				
r.	s thet t	by Ph		10	1 Yes 2 No 3 Probably 4 Unknow Wes en eutopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of death?									
ח אוושו ה	lew requires thet the death can as been signed by the ettend a 2 should be detached for una	o Be Completed b												
	The la								10	Yes 2 No	1 🗆 Yes	2□ No		
	To the Hospital or Attending Physician: The lew within 24 hours after deseth. To the Funeral Director: After this certificate has completely filled in by tha funeral director, page 2		25. Was cese referred to medical exeminer? 1 Yes 2 No	ospital:	7500	•□ ••	Other		eth (Check only o					
		Τ.	1 Yes 2X No 27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury		c. Injury e Work?	4 LI Nursing I	ome 5 Resi	how injury occur				
		Certification	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete)				
		edical	29e. Certifler (Check only one) 1X Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and menner stated.											
		Σ	29b. Signatura and title of certifies 29c. License number							29d. Dete signed (Month, Day, Year)				
	12		30. Name end eddress of person who cor	npleted cause of deeth (Ite	em 23a) (Type P		095	26		July 8	8, 199	8		
	10		Francis Bruno				ıtııx4	ont Pl	wy Col	umbia.	MD			
	Sta Registr		31. Dete filed (Month, Dey, Year)	32. Registrer's Sign	neture			- T- T- T- T- T- T- T- T- T- T- T- T- T-	y					

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Beg. No.

						C	ertificate	e of	Deat	h		Reg. No.	20	21216	
Physici	an	1. Decedent's Ner		•							2. Dete of D		Yeer	3. Time of Death	
/Medic		JAMES NURDERI GRANNAN									JULY	3, 1	3, 1998 6:30		
Examir	ner	4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or									ocation of Dee	on of Deeth 4c. County of Deeth			
		t-man		ICE LANE						CONSV			BALTI	MORE	
neral		5. Sociel Security		6. Sex 1⊠M 2□ F		yrs. last birthda	y) if Under Months	1 Year Deys	if Und	ler 24 Hrs. s Min.	8. Dete of B	irth ey, Year)	9. Birth	ptece (State or Foreign	
ector		316-10-7			87	Yrs.						6,1911		DIANA	
E 40		10e. State	10b. County		10c.	City, Town or	Location						T.	10d. Inside City Limits	
Lnottfind at	ō	MD	BAL	TIMORE		C	ATONSVI	TIE	7					1 ☐ Yes 2 ☐ No	
DOU	Director	10e. Street end N	1				10f. Zip		4		10g. Citizen of What Country?				
X		711 MATDEN CHOICE LANE												,	
No. marie	era	TIT MATUEN CHOICE LANE 21228 11. Meritel Status 12. Wes Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Origin? (Sp	ecify Yes or N	0- 14. Re	S.A.	can Indien,		
	Funeral	1 Never Mei	d 1 Yes	Armed Forces?			If Yes, specify Cuben, Mexican, Puerto Rican,					, etc.) Bleck, White,			
	þ		4 Divorced	If Yes, G	If Yes, Give 1 ☐ Y Yeer or Dates:			☐ Yes 2 No Specify:					Specify: WHITE		
	8	.=-	15. Decadent's	Education		16e. De	6e. Decedent's Usuel Occupation					16b. Kind of B	Business/In	dustry	
	ple		grade completed)		(Gi	(Give kind of work done during most of working life. DO NOT use retired)									
	Completed	Elementary/Secondary (0-12) College (1-4or 5+) PHOTOGRAMMER									FEDERAL GOVERNMENT				
	Be											- 10 10 miles in			
poce.	ToE	BARTHOL	OMEW GRA	ANNAN						EMMA	EISEN				
		19e. Informent's N	Name/Reletionshi	p (Type, Print)		19b. Me	iling Address	(Street	end Nun	nber or Run	al Route Numb	per, City or Town	, State, Zip	Code)	
		FREDERICK GRANNAN (NEPHEW) P.O. BOX 454 - WESTF							ESTFI	ELD, I	NDIANA 4	6074			
		20e. Method of Dis		По		b. Plece of Dis		e of			Dete	20c. Locetion		own, Stete	
			5 Other (Spe	3 □Removei from ecify)	G.	ATE OF				RY 7	/9/98	SILVER	SPRTI	VG. MD	
ouce.		21. Signature of F	unerel Service Li	censee			22. Name end IUBBARD					023721	OT ICE	10,110	
8		NK		· X.	2							AODE ME			
		23a. Pert1. Enter shock, or he	the disease, or c	omplications that	caused the d	eeth. Do not e	enter the mode	of dyl	ng, such	es cardiec	or respiretory	MORE, MI) 2.	1229 Approximete	
cian		Shock, of ne	ert reliure. List o	nly one cause on	ech line.								i	Intervel Between Onset end Death	
icai		immediate Cause (Final disease or condition a CONGESTIVE WEART FAILURE								0.2	i	4000			
er		disease or conditi resulting in deeth)	on	θ		O (or es e cons		1. 1	CARC	. (*	14/00	ice	- 1	TEARS	
-	ner				5401	0 (01 03 0 00110	oquoriou ory.								
	Examiner	Sequentially list of	onditions.	b	Due to	o (or es e cons	equence of):								
		Sequentially list of if eny, teeding to licause. Enter Und Cause (Disease o	mmediete erlylng												
-	Medical	C. — Due to (or es e consequenca of): Tesulting in deeth) Lest Due to (or es e consequenca of):													
	Med														
	lan	d.													
	Physician	Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.									23b. Did tobacco use contribute to the cause of death?				
		APLASTIC BASTA							1 Yes 2 No 3 Probably 4 Unknown						
	þ	TITCHSTIC MINEMIN													
	ted	BLASTIC ANEMIA								24e. Wes	ere eutopsy findings elleble prior to				
	Completed	77.00000								, , ,		of	mpletion of cause death?		
9	Con										10	Yes 2000	10	Yes 2000	
	Bec	25. Wes case referred to medical													
	To	exeminer?	ŊNo	Hospitai:	Inpatient 2	ER/Outpeti	ent 3 DOA	Oth	or:	Nursing Ho		Idenca 8 🗆 Ot	ner (Specif	y)	
		27. Menner of Dee	th		of Injury th, Dey Year			-				how injury occu			
	atic	27. Menner of Death 1 Maturet 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 1 Yes 2 No													
	Certification:	3 Sulcide 4 Homicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)													
	Cer			Guildi	g, att. (ape						Only or 10	, olalej			
		29a. Certifier (Check only	Certifying	Physician: To the	best of my k	nowledge, de	oth occurred at	the tir	ne, dete	and pleca,	end due to the	cause(s) and m	enner as s	teted.	
	edical	one)	Z Medical EX	aminer; On the b end men	ner steted.	metion aud/or	investigetion, I	птус	pinion, di	eetn occurr	ed et the time,	uete end place,	and due to	tne cause(s)	
	Σ	29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Date signed)													
		1 /MW V. Non D44748 JULY 8									8	1558			
		MATTHEW V. MARKET 711 MAIDEN CNOICE LANE CATONSHILLE, NO													
		MATT		1. 1/1	nn K	7	11 MAI	DEN	CNO	DICE	LANE	CATON	511/10	EMP	
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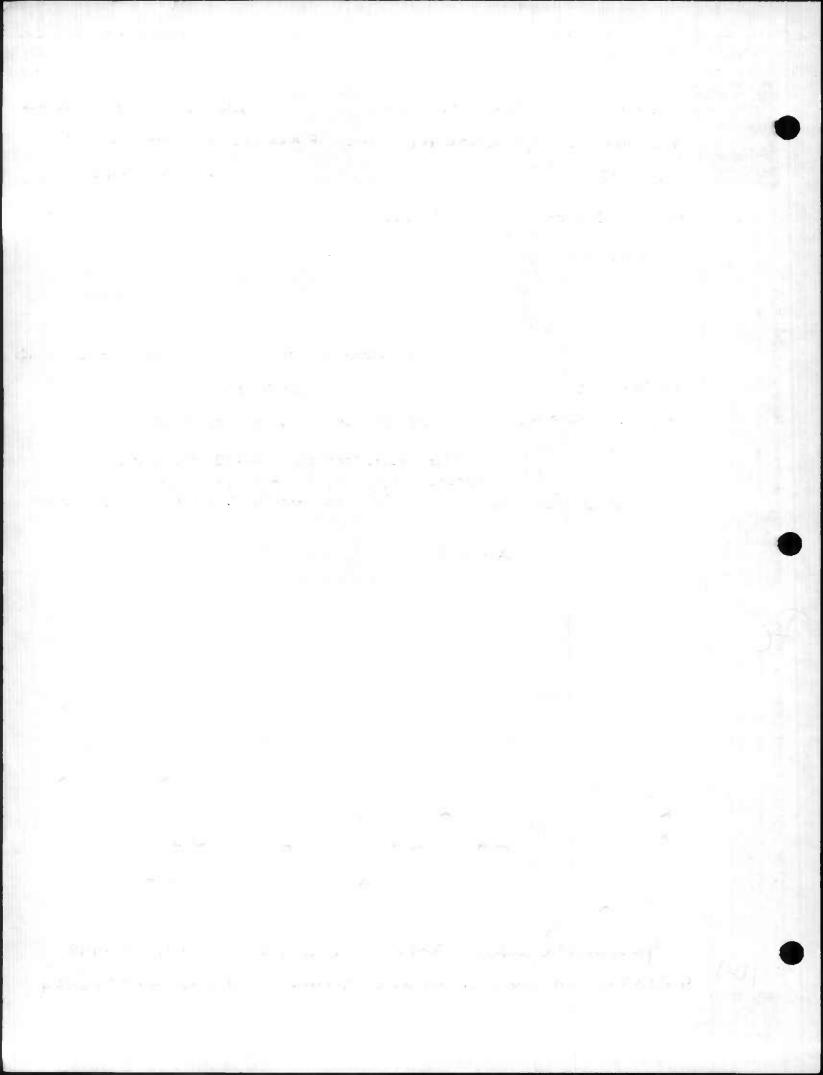
State of Maryland / Department of Health and Mental Hygiene

				C	Certificate of	Death	F	Reg. No.	0	61611
Observat	,	Decedant's Nama (First, Middla,	•		V		2. Data of Dea Month	ath Dey	Yaar	3. Time of Death
Physic /Med		JOHN A	12THUR	9E10	GER		シント		98	19=20 425
Exam		4a. Fecility Nama (If not institution,				4b. City, Town, or L	ocation of Death		of Death	
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Directo		221-24-6130 Usual Rasidanca of Decedant	7. Aga	59 Yrs	Months Days	Hours Min.	8. Data of Birth (Month, Day Sept. I	8,1938	Dela:	ware
ye m		10a. Stata 10b. County	1	Oc. City, Town o	r Location				10	d. Insida City Limits
Mary Ash	ō	MD Harfo	rd	Bel A	Air					1 □ Yes 2 No
the	Director	10e. Street and Number			10f. Zip Coda			10g. Citizen of V	Whet Count	trv?
with 6		1522 Cedarwood	Drivo		21014	1		United		
leath m 2	era	11. Marital Status	12. Was Decedant Ev	ar In U.S.					e - Amarica	
72 hours efter death with the Maryland "naturel", or frems 23e or 28a-f show edical Examiner must be notified at	by Funeral	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forcas?		13. Was Decedant of If Yas, specify Cul 1 ☐ Yas 2 1 No		Rican, atc.)	Specify Specify	ck, Whita, a	itc.
2 hou		15. Decedant's	Education	16a. De	ecedant's Usual Occu	pation		16b. Kind of B	usinass/Ind	ustry
in 7	pet	(Specify only highest	grade completed)	(G	giva kind of work done ta. DO NOT usa ratin	during most of worked)	king			
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be filed tal Hygid d other event, in		17. Fether's Name (First, Middla, La				18. Mother's Nam	e (First, Middla,			TILL IMIL
o da p	o Be	Melvin Geiger				Grace Go	dwin			
d 2 should by th and Menta 7 is marked treumatic ev	To	19a. Informant's Name/Relationship	(Type Print)	19h M	lailing Addrass (Stree			or City or Town	State 7in	Code)
d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		Sandy C. Geiger			2 Cedarwoo					0004)
Heali om 2 ther		20a. Mathod of Disposition	,				Data Data	20c. Location -		wn State
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permit. Peg Department Important: ii any injury o		21. Signeture of Funaral Sarvica Li	cansee Mo	0382		ess of Facility D.I.				
	-	Super C	Ohuman							MD 21286
		23a. Part1. Entar tha diseesa, or co shock, or haart failura. List or	ity ona causa on aach lina.	a daath. Do not	aniar tha moda or dy	ing, such as cardiac	or raspiratory ar	rast,		Approximata Intervel Batween
Physiciar		A CONTRACTOR OF THE							1	Onset end Death
/Medica	_	Immediata Causa (Final disease or condition	Asa	C 1						
LAdillile		rasulting in daath)	Du	ua to (or as a cor	nsequance of):					
ind transit	Examiner	Sequentially list conditions,	■ b	a to (or as a cor	nsequence of):					
uriel-		Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaase or Injury								
3 6	edicai	that initiated evants rasulting in death) Last	CDu	a to (or as a con	saquanca of):					
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death ce e attendi xd for use	icla	Pert II. Other significant condition	contributing to death but	not rasulting in th	na undarlving causa g	ivan In Part I.	23b. Dfd t	obacco use co	ntribute to	the cause of death?
mat me ed by th detache	by Physician/									ably 4 Unknown
law requires as been sign 2 should be	Completed t						24a. Was perto	an autopsy med?	ava	ra autopsy findings illabla prior to inpletion of cause laath?
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certificate		25. Was casa rafarrad to medical				26 Plane of Dec				
ls certific director,	o Be	axaminar?	Hospital:	08500	O	26. Placa of Dea			(0	A
5 E	 	1 Yas 2 No 27. Mannar of Death	1 ☐ Inpatient 28a. Data of Injury	2 ER/Outpe	atient 3L DOA	4 Li Nuising H	oma 5 Rasid	tance 6 ∐Oth now Injury occur		7
the une	ion	1 Matural 5 ☐ Panding	(Month, Day Y	<i>'ear)</i> Inju	ry Wo	ork? Yas 2 Vo				
the the	Ical	2 ☐ Accident investige 3 ☐ Suicide 6 ☐ Could no	be 280 Place of Injury	At home form				Street end Numl	her or Dural	Route Number
after deat Director: I in by the	Certification:	4 Homicida datamin			, streat, factory, offica	1	City or Tow	vn, Stata)	oer or Mural	noute wimper,
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within 24 hours after of To the Funeral Direct completely filled in by	edical		Physictan: To the best of a aminar: On the basis of a end mannar state	camination and/o						
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		gamen	12-1- ha	DM	= 0	CME	•	July (216	448
101)		30. Nama and addrass of person w	no complated cause of dea			0 10 0		- 1		
	۱ I	and and address of person wi	o completed badda of daa	" (man soa) (I y	post i may					

State Registrar

4. PRASHUM-D. 218 FULFORD AUF BELAIN 10 21014

31. Data filad (North, Dev. Yogg) 32 flagstrat Signature Pandsle



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene SHARA DENNE GAYLORD Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** JULY lora 8, 9:46 AM eneen /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner JOHNS HOPKINS HOSPITAL E.R. BALTIMORE If Under 1 Yeer | If Under 24 Hrs. Months | Deys | Hours | Min. 7. Age (In yrs. last birthday) 5. Sociel Security Number 8. Dete of Birth **Funeral** 30 Months Deys Hours 1□M 20 F 214-90-0360 Yrs. **Director** with the Maryland 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Numbe 10f. Zio 10g. Citizen of What Country? pernit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flems 23a and Injury or other traumatic event, the Modical Examiner manages. Funerai 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien Black, White, etc. 1 ☐ Yes 2 No If Yes, Give / Yeer or Detes: 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specity: B þ 3 ☐ Widowed 4 ☐ Divorced acla Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) ounsel 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Ma Be IDY State, Zip Code) 21133 e/Reletionship (Type, Print, 19b. Mailing Address (Street and Number or Rural Ro 20 lord 20e. Method of Disposition 20b. Pleca of Disposit 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funerel Service Leaning Nam ong as Or 1701 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequenca of) Division of Vital Records, P.O. Box 687 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 3 ģ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed certificate 2 No 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 2 XXYes 2 No 1 ☐ Inpatient 2XXER/Outpetient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of injury 28d. Describe-bow injury occurred 28c. injury at Work? Certification: 5 Pending investigation or Attending 1 Natural 1 Yes 075414% 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Direc Homicide

State

Registrar

Medical

31. Dete filed (Month, Jey, Year) 0 1998

Medel

30. Name and address of person who completed cause of down (Item 23e) (Type, Print)

29a. Certifier

(Check only one)

29b. Signeture end title of certifier

111 Penn Street, Baltimore, Maryland 21201 32. Registrat's Signature

Julia Davidson

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as state

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) end menner stated.

29c. License number

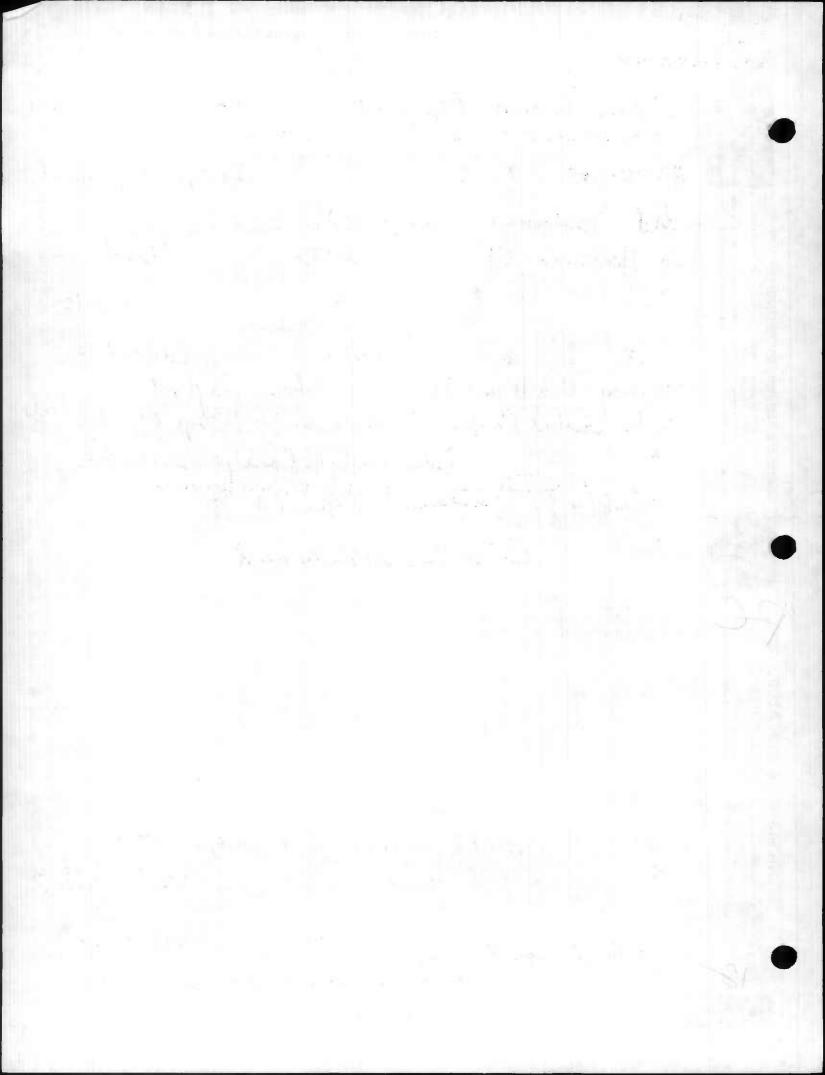
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29d. Dete signed (Month, Dey, Year) 9, 1998

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Yeer **Physician** 1:08 pm July 8,1998 Myrtice /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year Months Days if Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) 5. Sociei Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthpiace (State or Foreign Country) **Funeral** 1 M 2 K F 2/7-84-3/89 Usual Residence of Decedent FEB. 19,1962 **Director** Mary/mo 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Modical Examiner must be notified at Harylano Baltimore
10e. Street and Number 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 21286 402 RailROAD USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritei Status 2 should be filed within 72 hours effer end Mental Hygiena. Is marked other than "naturel", or ite Never Married 2 ☐ Married ☐ Yes 25 No Yes, Give 1□ Yes 2No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry MUSELD'S SCHOOL Elementery/Secondary (0-12) Coilege (1-4or 5+) TEACHER 45 ARS 17. Father's Name (First, Middle, Last) 18 Mother'e Name (First, Middle, Maiden Sumeme) ROBINSM BEATTICE Why & BERNOVO 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 st Department of Haalth enc important: if item 27 ie n any injury or other treun Towson, Med 21286 407 RAILKOAD AUG IM GTHER BEATTICE WHYE 98 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) VALLEY MONERIAL liHONIUM Rd Gorsen 21. Signeture of Funeral Service/Licensee 22. Name and Address of Facility OHA TMM HOM'S 23a. Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Home. Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) a Hypercarbic Respiratory Failure 48 hours Examiner Due to (or es e consequence of): Physician/Medical Examiner Fibrosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequenca of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 2 1 Yee 2 No 3 Probably 4 Unknown recurrent Ps eudomonas Pneumonia signed I 24a. Was an autopsy performed? 24b. Were autopsy findings evallable prior to completion of cause of death? Completed 10 Yes 2□No 1 Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica complately filled in by the funeral director; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Dunpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Date of injury (Month, Dey Year) 28c. injury at Work? 28d. Describe how injury occurred 5 Pending 1 ANatural 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Cartifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end menner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 97008 gborbesong July 9, 1998

JHBMC 4940 Eastern Are Balt, MD 21224

State Registrar 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrary Signature

Patience Aqborbesong, MD

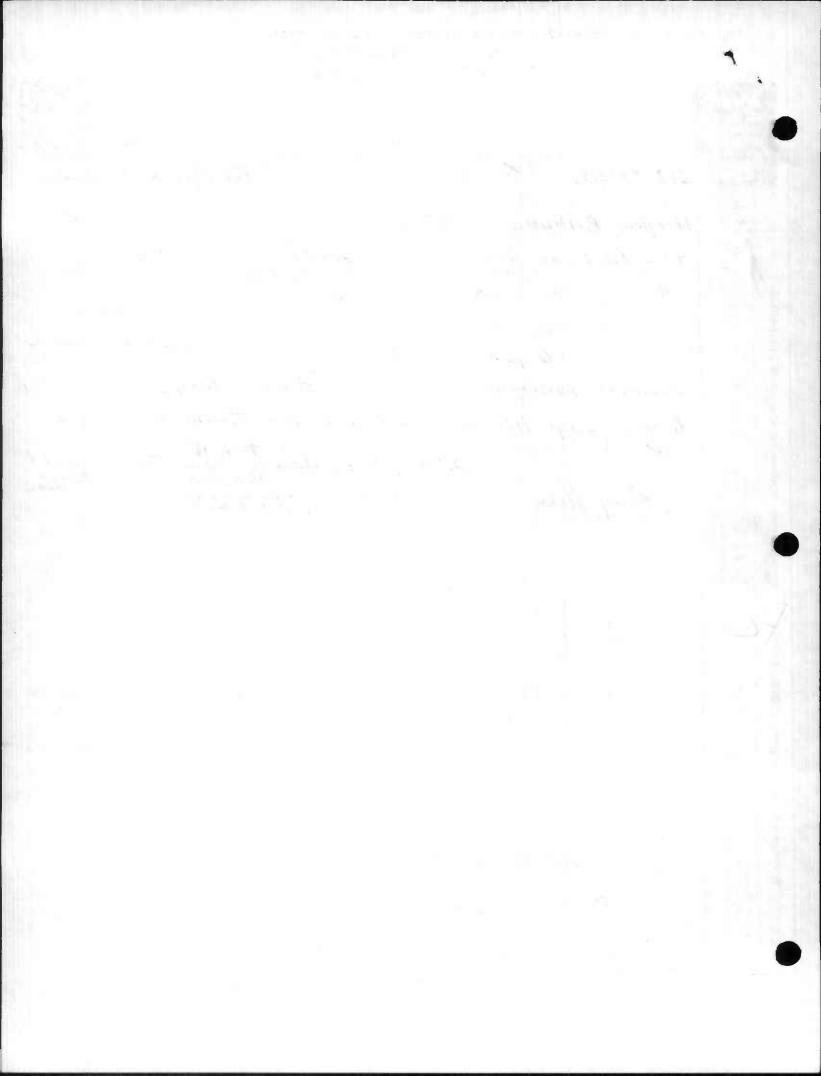
31. Date filed (Month, Par, Year) 1998

Baltimore, Maryland 21215-0020

Box 68766

P.O.

Division of Vital Records,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month GILLARD 5 1 THOMAS 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death DEATON BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex № M 2□ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 54 Yrs MAY 23, 1944 SOUTH CAROLINA 240-70-6981 10a Siale 10b. Count 10c. City, Town or Location 10d. Inside City Limits GLEN BURNIE 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 446 JUMPERS COURT 21061 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 N Yes 2 No 1967-If Yes, Give Year or Dates: 1980 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) U.S. ARMED FORCES ARMY 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN) (UNKNOWN) (UNKNOWN) (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 446 JUMPERS COURT, GLEN BURNIE, MARYLAND MARILIN GILLARD (WIFE) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremallon 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MARYLAND VETERANS CEMETERY 7/10/98 CROWNSVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximete Interval Between Onset and Death Immediate Ceuse (Finel Endstage renal disease. 6 year disease or condition resulting in death) yeal. Nephropath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Din dependent diasetes mellity. Arthrocelesofie condiovascular disere Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Periphral vascular dissoese, Hepatitisc 1 Yes 2 No 3 Probably 4 Donknown Bilateral below Knee ampulation. 24e. Wes en eutopsy performed? 24b. Were autopsy findings evallable prior to completion of cause of death? artery disease DVT 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 ☐ Pending investigation 1 DMatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner as steted.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital death. To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the for

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traumatic event, the Medical Examiner must be notified at

the Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 325 Hospital Dague 202, GLENBURNGE, MD 21081 GURMEET .S SAWHNEY MD 32. Reginalia Signalythan Randall

- S MD

29c. License number

D44973

29d. Date signed (Month, Day, Year)

31. Date filed (Month) Pay, 1ear 1998 State Registrar

Medical

29b. Signature and title of certifier

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death Month Day 1990 4c. County of Death 8:48 Aug **Physician** GRAD DOROTHY JULY /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) Examiner Baltimore Boltimon Il Under 24 Hrs. Medica Northwest enter Lounty 8. Defe of Birth (Month, Day, Year) 9. Birthplece (State or Foreign Country) Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** North Ceraline 10 M 20 F Months Days Hours Min 318-22-4899 Usual Residence of Decedent 74 Yrs. Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. writ: If time 27 is marked other than "nature!", or items 23s or 28s4's show urt; of them 27 is marked other than "nature!", or items 23s or 28s4's show urt or other traumatic event, the Medical Examiner must be not lead as 10b. County 10d. Inside City Limits 10e. State 10c. City, Town or Location 1 Yes 2 No Directo 10 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 90 2/2/ Funeral 200) 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race -American Indian. 11. Marifai Status Bleck, White, efc. 1 Yes 2 No If Yas, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2₽No Baltimore, Maryland 21215-0020 Specify: þ CCK 3 Widowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etamantary/Secondary (0-12) College (1-4or 5+) Homemaker 124 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be 2 Himi James allum. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date 20c. Location - City or Town, State JUNICE Ucuchter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it 1 Buriai 2 Cremetion 3 Removal from State altenore, Mary and 4 ☐ Donation 5 ☐ Other (Specify) Kern emorie 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jeff Milter, P.C. Funeral Balto. Md 1639 N. Broodway 23a. Part L Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximata Interval Between Onsef and Death **Physician** Pan creak Immediate Cause (Final disease or condition resulting in death) /Medical Mos **Examiner** Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediata cause. Entar Underlying Causa (Disaasa or injury that initiated events resulting in death) Lasf Dua to (or as a consaquence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part It, Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 25 No 3 Probably 4 Unknown signed t þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? certificate has b lirector, page 2 sl 1 🗆 Yes 2 3400 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cese referred to medical exeminer? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA After this funeral 28d. Dascribe how injury occurred 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accident after death Director: 6 Could not be datarmined 3 Sulcide 28a. Place of Injury - Af homa, farm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Funeral Direct 4 Homicide 29a. Certifier Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. edicai

State

(Check only one)

29b. Signature end titly of

30. Name and adds s of persor

31. Date filed (MILL Day, Year) 998

Registrar

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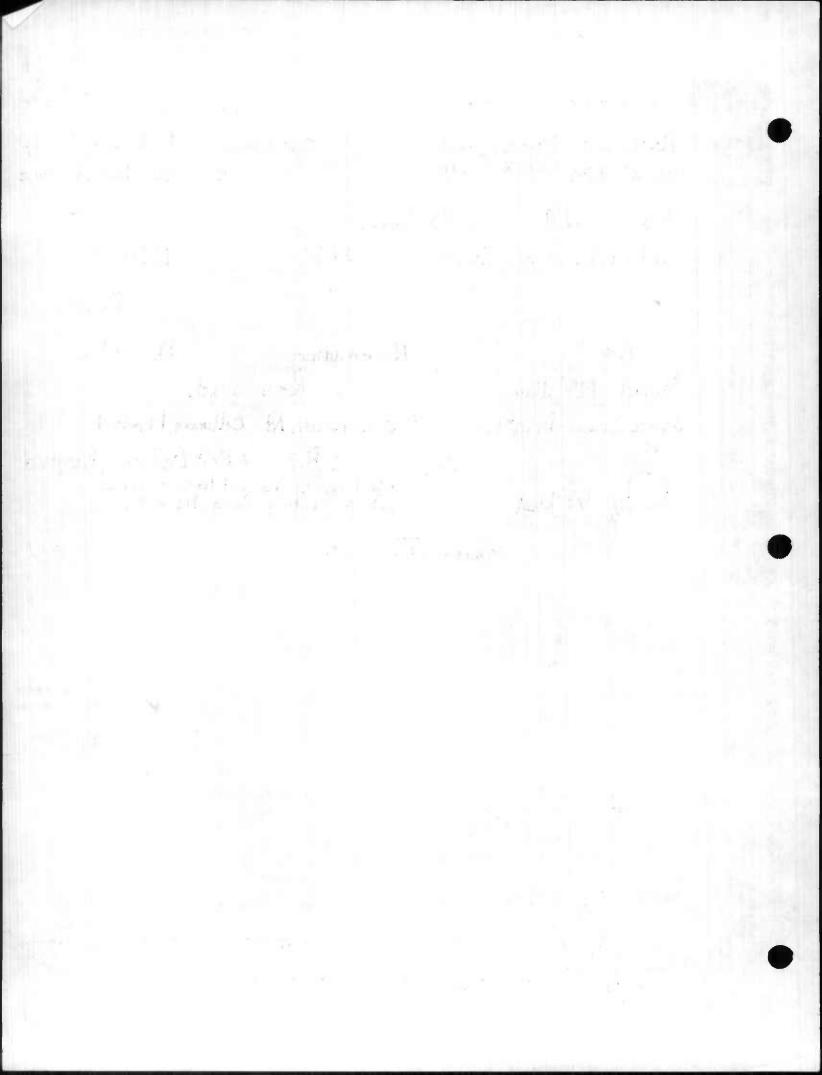
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who comptated ceuse of death (Itam 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dev. Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Deta of Death Month 3. Tima of Death Year **Physician** ETHEL GREENHILL UNKNOWN JULY 07 1998 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 48 SHERIDAN BALTIHORE AVENUE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 200 F 69 Yrs. Months Days Hours 217-24-6758 Director Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene.
int: If Item 27 is marked other than "natural", or Items 23s or 28s-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits traumetic event, the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND 10e. Street and Number 1 g. Citizen of What Country? SHERIDAN AVENUE by Funeral USA. 12. Wes Decedent Ever in U,S. Armed Forcas?

1 Yes 2 No if Yes, Give Yeer or Detes: 11. Marital Stetus Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 1 Never Married 2 Merried Baltlmore, Maryland 21215-0020 1□Yes 2DNo Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12+ GRADE CERTIFIED DIETIAN ASSISTANT CHILDREN'S YRS 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) Be To WILLIAM SADIE DORSEL 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code, nt of Heelth a : If Item 27 is or other tra RAYMOND GREENHILL (HUSBAN) BALTIMORE, MD, 21239

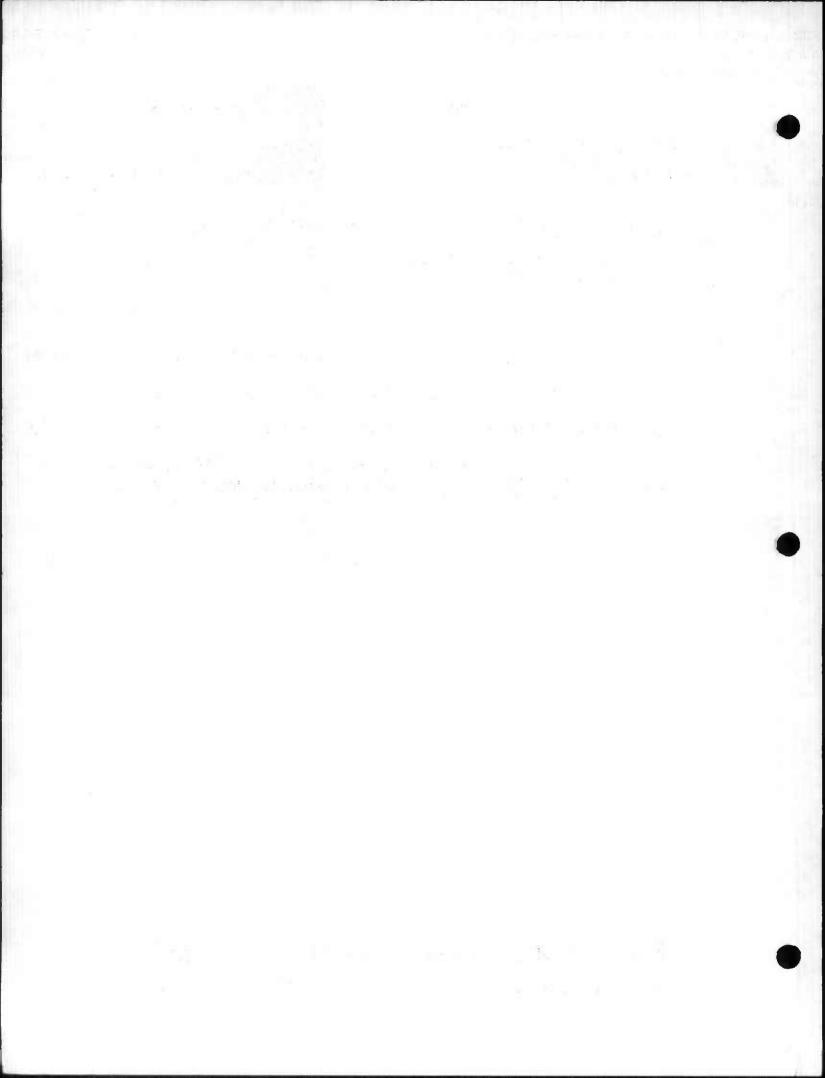
20c. Location - City or Town, Stata 1248 SHERIDAN AVE. Place of Disposition (Nema of cemetery, cremetory or other place) 20e. Method of Disposition Dete 1 MBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Pege Department of Important: If any Injury or 7-10-980 WINGS MILLS, MD, 4 Donetion 5 ☐ Other (Specify) GARRISON FOREST 21. Signature of Funerel Service JOSEPH H. BROWN JR. FUNERAL HOME, P.A. ð FULTON AVENUE, BALTIMORE, MD. 21217 23a. Pert1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between **Physician** /Medical Immediate Cause (Final 16 mos. disease or condition resulting in deeth) crian Examiner Due to (or es e consequenca of): The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest and Due to (or es a consequença of) P.O. Box 68760. nding physician Physician/Medicai Due to (or es a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 Yes 2 No 3 Probably 4 ☐ Unknown of Vital Records, þ 24b. Were eutopsy findings aveilable prior to completion of ceuse of death? Completed 24e. Wes en autopsy 1 Yes 2 No After this certificate or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) axaminer? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: Division 5 Pending Investigation 1 Naturel 2 Accident death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral C completely filled 1X Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner as stated.

2 Medical Examinar: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier eg g 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) quare Day, Year) L 1 (1998 32. Registrer's Signeture State

Fulia Davidson-Randalle

DHMH 16 Ray 6/95

Registrar

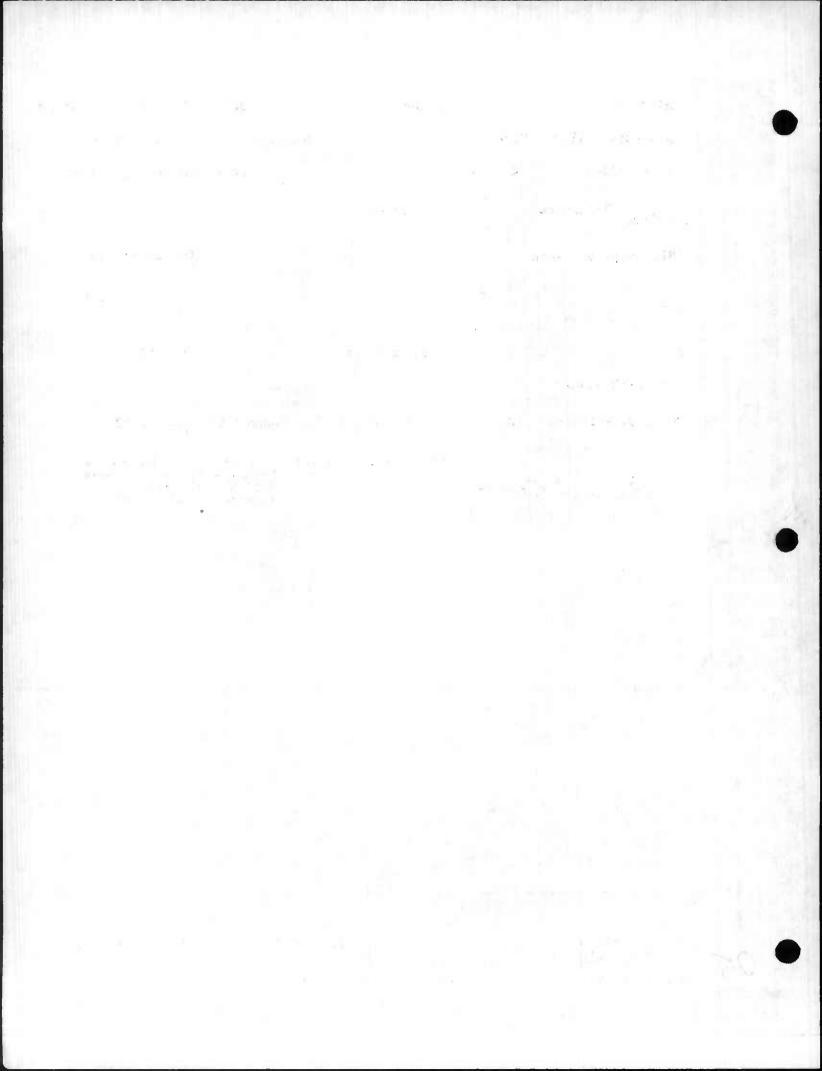


State of Maryland / Department of Health and Mental Hygien

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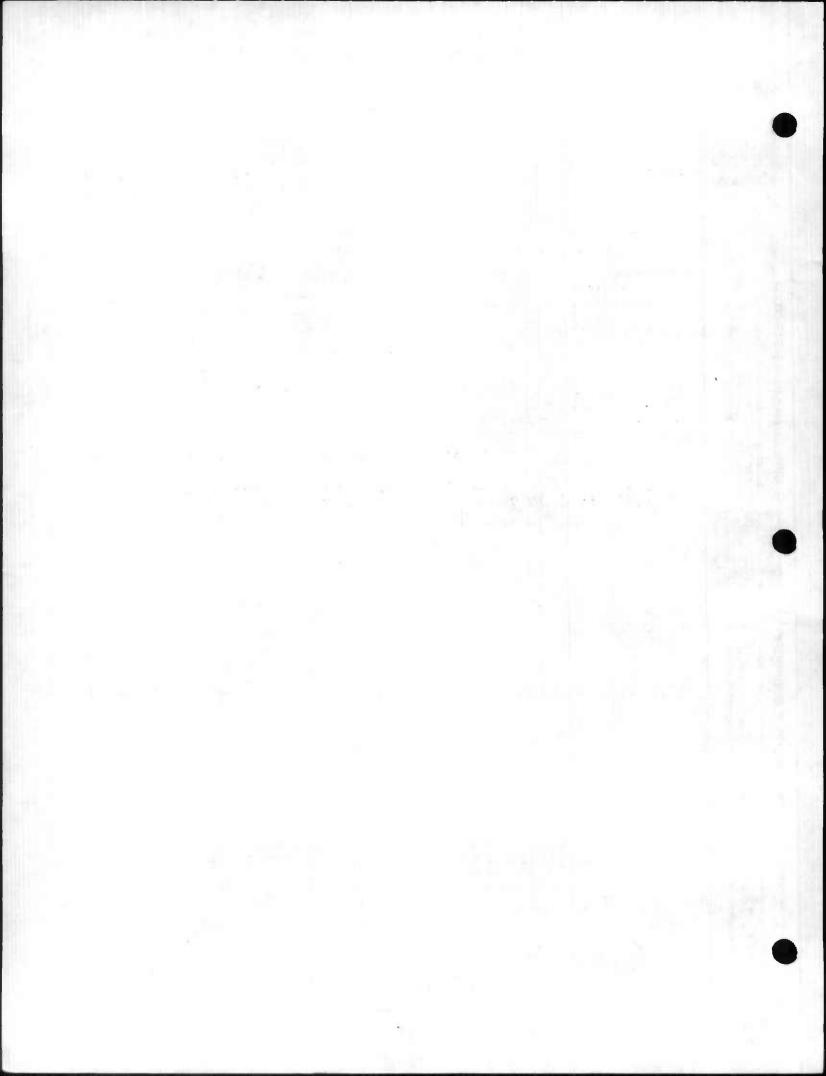
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Physicia	ın	Decedent's Neme (First, Middle							2. Dete of Dee Month	Dey	Yeer	3. Time of Deeth
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Examine	er	4e. Fecility Neme (If not institution Augsburg Luth						own, or Loca timore	ation of Deeth		y of Deeth timoi	
nerai		5. Sociel Security Number	6. Sex		s. lest birthday)	If Under 1 Yea Months Day		24 Hrs. 8	B. Date of Birt	h V Year)	9. Birth	nplece (State or Foreign
ctor		216-24-5615 Usuel Residence of Decedent	1□ M 2√ F	88	Yrs.	livorano Day	110013	J	July 25	,1909	Mar	yland
Examiner must be notified at		10a. Stete 10b. County			City, Town or Lo							10d. Inside City Limits
	Director	Maryland Baltin	nore		Baltimo	re						1 ☐ Yes 2 💢 No
	Dire	10e. Street end Number				10f. Zip Code				10g. Citizen of	Whet Cou	untry?
	era.	6811 Campfield				21207				United		
	Funeral	11. Meritel Stetus 1 ☐ Never Married 2 ☐ Married	Armed	ecedent Ever in Forces?	U,S. 13. V	Wes Decedent of Yes, specify Cu	l Hispenic Ori Iben, Mexicer	igin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	14. Re	ck, White	icen Indien, , etc.
	É	3 ₩ Widowed 4 Divorced	If Yes, or	s 2 ☑ No Give Detes:		□ Yes 2💢 N	o Specify:			Specia	y: Wh	ite
	Completed	15. Deceden (Specify only highe	t's Educetion	d)	16a. Deced	lent's Usuel Occ kind of work don	upetion	et of working		16b. Kind of B	usiness/li	ndustry
	nple	Elementery/Secondary (0-12)		(1-4or 5+)	life. L	OO NOT use retii	red)	a or working				
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1	ို	Frederick Sande			40h Adeliin		un				a	
		Roger S. Weinbu				y Address (Stree						ip Code)
		20e. Method of Disposition	irg - roa			York Rosition (Name of netary or other p		utner	Dete Dete	MD Z1	093 City or T	Fown, Stete
		1 X Buriai 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S		m State				h / 1	1 /00			
	ŀ	21. Signeture of Funeral Service		L C		ark Ceme . Neme end Add				Baltim k Funer		
9		Rica	2. Chr	_				3620	Wilke	ns Aven	ue	Ome
r	7	23a. Part1. Enter the diseese, or shock, or heert feilure. List	complications the	t ceused the dee	eth. Do not ente	er the mode of ch	ying, such es	cardiac or i	imore,	MD 21	229	Approximete
n		Shock, or neer tellure. List	only one cause or	n eech iine.								Interval Between Onset end Deeth
i i		Immediate Ceuse (Finel disease or condition	_		1/-	25						6 mos
r		resulting in deeth)	θ	Due to	(or es a conseq	uence of):						0 11.00
ď	- Le		b		Olgin	1145 5	nor bry	ne			1	6 mos
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or es e c ons eq							
		ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events	C								1	
1	n/Medical	resulting in death) Lest	1	Due 10 (or es e consequ	ience of):						
1	Z		d							- 4		
13	SICE	Pert il. Other algnificent conditio	na contributing to	death but not re	suiting in the un	dertying ceuse o	iven in Part I.		23b. Did to	obacco use co	ntribute 1	to the causa of death?
100	Physicia									es 225No		obably 4 Unknow
1	ò			14.5	CVD							
3	Completed								24a. Wes e pertor		(A)	Vere eutopsy findings vaileble prior to
100	d										of	ompletion of ceuse f deeth?
									1□Y	es 28No	1	☐ Yes 2☐ No
ď		25. Wes cese referred to medical exeminer?	Hospitei:			10	thor:		Check only or			
	0	1 ☐ Yes 2 ☑ No 27. Manner of Deeth	11	Inpatient 2 C	ER/Outpetient	3LI DOA				ence 6 Oth		ify)
1014	Certification:	1 Naturel 5 Pendin	g (Mo	onth, Dey Year)	28b. Time of Injury	28c. Inj W	ork? ⊒Yes 2 □ I		u. Describe n	ow Injury occur	red	
161	100	3 Suicide 6 Could r	not be 28e. Pled			et, fectory, office	9	281			er or Rur	ral Route Number,
1	Le l	4 ☐ Homicide determ	buil	ding, etc. (Speci	ity)				City or Tow	n, Stete)		
odice!		29e. Certifier 1 Certifying (Check only one)	g Physician: To the Examiner: On the end me	ne best of my kno basis of examine enner steted.	owledge, deeth etion end/or inv	occurred et the i	time, date end opinion, deet	d plece, and th occurred	d due to the c el the fime, d	euse(s) and ma lete and plece,	anner as a and due t	steted. to the ceuse(s)
Medical Cartification		29b. Signeture end title of certifier				29c. Licer	nse number		2	9d. Dete signe	d (Month,	Day, Year)
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1	- 1	30. Name and address of purson of				Print)			A 2 15	713		(10
State		Jef Zibel MD 31. Dete filed (Month, Dey, Yeer)	32.	Park H. Registrer's Sign	eture	HUR	Baltin	name	WA	212	08	
istrar		JUL 1 0 19	98	police David	bon-Rand	all						
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State of Maryland / Department of Health and Mental Hygiene

	Decedent's Neme (First, Middle, La	ist)		001	anouto (of Death	2. Date of Dea			3. Time of Deeth
cian Iical	Ralph			Gold	dberg		July July	8, 199	Year 98	12:24am
iner	4a Facility Name (If not institution, give Meridian Spa Creation)	Action Colonial Colonial					r Location of Death		1.00	
1	5. Social Security Number 6. 5			last birthday)	If Under 1 Y		rs. 6. Deta of Birt	Anne	9. Birthpla	CE (State or Foreign
	120-10-2400	IÇM 2□F	72	Yrs.	Months De	ays Hours Mi	Oct.8,	1925	New Y	
	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	cation				100	J. Inside City Limits
ctor	MD Anne Aru	ndel 	Edg	water						1□Yes 2□No
al Director	3701 Baypoint Dr:	ive			10f. Zip Coo 2103			10g. Citizen of V USA	What Country	n
runeral	11. Merital Status	12. Wes Decedent Armed Forces?	?	,S. 13. W	Vas Decedent Yes, specify (of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Rac Bled	e - Amaricar ck, White, et	
	1 ☐ Never Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	It Yes, Give Ty Year or Dates.	WII	1	☐ Yes 2☐	No Specify:		Specify	Whit	е
	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Deced	ent's Usual Ockind of work do	ccupation one during most of w stired)	rorking	16b. Kind of B	usiness/Indu	stry
	Elementary/Secondary (0-12)	College (1-4or	5+)	Electr		Engineer		Flooty	ri o	
	17. Father's Nama (First, Middle, Last,)		DIECCI	OHIC		ame (First, Middle,	Electr Maiden Sumen		
	Sam	Goldbe	erg			Jeann	e Arrowit	z		
	19a. Informent's Name/Relationship (Richard Goldberg					se Ct. El			State, Zip C	
	20a. Method of Disposition			Place of Dispos	sition (Name o	1	Date	20c. Location -		
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			. Hebro		tery	7/12	Queens,	New Y	ork
	21. Signature of Faneral Service Licer	nsee	1			dress of Facility Funeral	Home, P.A	١.		
	/ Mones /	Horder	4	12	Ridge	ly Ave. A	nnapolis,	MD 21	401	pproximate
	23a. Part 1. Enter the disease, or com shock, or heart feilure. List only	one cause on each li	ine.	ii. Do not ente	a the mode of	dying, sour es caro	ac or respiretory ar	1631,		nterval Between Onset and Death
	Immediate Cause (Finel disease or condition			Prou	min i	_				luh
ı	resulting in death)		Due to (c	or as a consequ	uence of):					
	Sequentially list conditions	b	Due to (c	r as a consequ	uence of):					
ı	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C							i	
	that initieted events resulting in death) Last		Due to (o	ras e consequ	uence of):				į	
		d								
	Part II. Other significant conditions of	contributing to death b	out not res	ulting in the un	derlying cause	given in Pert I.	23b. Did 1	obecco uee co	ntribute to t	he cause of death?
							10	Yes ZENo	3 Probe	bly 4 Unknow
								an autopsy rmed?	com	e autopsy findings able prior to pletion of cause
							101	res ZONo		eath? Yes 2□ No
ŀ	25. Was case referred to medical examiner?					26. Place of D	eath (Check only o			
	1 Yes 2 No	Hospitel:		ER/Outpatient			Home 5 Resid			
	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		njury at Work? 1 Yes 2 No	28d. Describe i	now injury occur	red	
	3 Suicide 6 Could not b determined	28e. Place of In- building, et	iury - At h c. (Specif	ome, ferm, stre	et, factory, off	ice	281. Location (S City or Tox	Street end Numb vn, State)	per or Rurel	Route Number,
	(Check only 2 Medical Exam	nysician: To the best niner: On the basis o	examina 1	wledge, death	occurred at the	e time, date and pla ny opinion, death oc	ce, and due to the curred at the time,	cause(s) and me date and place,	enner as sta	ted. he cause(s)
	one)	and manner st	ated.		29c. Lic	ense number		29d. Date signe	d (Month, D	ay, Year)
	29b. Signeture and title of βertifier					101			-1	
	29b. Signeture and title of pertifier	me				03793	6	//!	P/S/P	
medical	29b. Signeture and title of pertifier 30. Name and address of person who	completed cause of c	death (Item	23a) (Type, F	Print)	03263 Chal	MI	7/13	8158	



98-3854-017

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

KELLY **GROON**

	State of Maryland / Department of Health and	Mental Hygiene	100
ŒS	ITEMS: #23 PART I, 27, 28A-F PER MEO FILM G761 Certificate of Death	Reg. No.	166
	Decedent's Nema (First, Middle, Last)	2. Dete of Deeth	3. Tima of

Physician /Medical Examiner Deeth

Funeral

Director

with the Meryland r 28a-f show

2 should be filed within 72 hours after deeth with tand Mentle Hydiens, and Mentle Hydiens, are streeted often than "natural", or items 23s or saumatic event, the texts of the mast be augustic event, the texts of the mast be august to went, the texts of the mast be august to went, the texts of the mast be august to went, the texts of the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august the mast be august Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 st Department of Health and Important: If Item 27 is n any injury or other traun 9

> **Physician** /Medical Examiner

The law requires that the death certificate be executed attending physician end for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by the a irector, page 2 s or Attending Physician: director, this funeral death octor: / by the f n 24 hours after on Funeral Directors pletaly filled in by npletaly To the To the To the

05,1998 Kelly Lynn Groomes JULY 4:20P.M. 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth MONROE BAY CHARLES If Undar 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) 2-14-66 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) Months Days Hours Min 1 M M F 223-27-0298 Yrs. 32 D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Stafford Stafford VA Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 54 Shady Ln. 22554 USA Funeral 12. Wes Decedant Evar in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 11. Meritel Status Bleck, White, etc. 1 ☐ Yes 2₹ No If Yes, Give Yaar or Datas: 1 ☐ Never Married 2 ☑ Merried 1 Yes 2 XNo Specify: White by 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Caregiver Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Neme (First, Middle, Last) Be Judy Reid Ned Hall II 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22554 54 Shady Ln., Stafford, VA Gary M. Groomes 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete Chestnut Grove Cemetery 7/11/98 Herndon, VA 4 □ Donetion 5 □ Other (Specify) 22. Nama and Addrass of Facility Green Funeral Home, 721 Elden St., Herndon, VA and the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, cause on each line. Approximete tnterval Between Onset end Deeth Enter the disees or heart feilure. Immediate Cause (Finel disease or condition resulting in deeth) DROWNING Due to (or es e consequenca of): Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Physician/Medical Due to (or es a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed 2 No 20 No 25. Wes case referred to medical agaminer? Be 26. Place of Deeth (Check only one) axamineir 1 X Yes 2 □ No Other: 4 Nursing Home 5 Residence 8 Dother (Specify) RIVER Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Data of Injury FOUND 7-5-98 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation UNKNOWN M 1 Naturel 1 ☐ Yes 2 No UNKNOWN 2 Accidant 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, streat, fectory, office building, etc. (Specify) 28f. Location (Straat and Number or Rurel Route Number City or Town, Stete) MONROE BAY 4 Homicide FOUND IN WATER CHARLES CO., MD 1 Cartifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and pleca, and due to the cause(s) end menner stated. 29a. Certifier edical 29b. Sia ne end title of cartifier 29c. License number 29d. Data signed (Month, Dey, Year) O.C.M.E. JULY 6, 1998 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

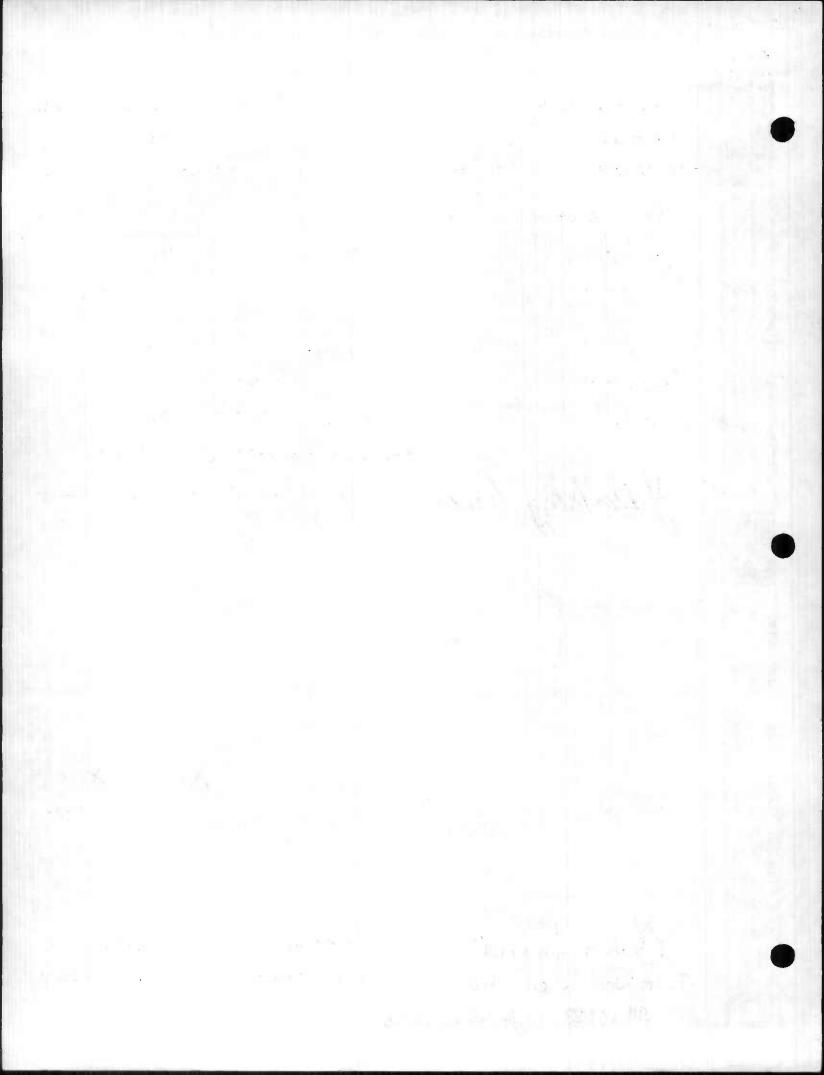
LA RON 31. Date filed (Month, Day, Year)

JUL 1 0 1998

32. Registrer's Signeture hulid Savidson Randope

MD

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CHARLES GROSS 1998 11:45 PM /Medical 4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Rose dale
If Under 24 Hrs. 8. Date Center Haspita Square Baltimore If Under 1 Year 8. Date of Birth Month. Dey. Year July 2, 1911 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign tX M 2□ F Months Deys Hours Min Mary Tand 215-03-0357 87 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d, toside City Limits Md. Baltimore Essex 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Ridgemoor 21221 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore City 12th 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Carl Gross MAry Marley 19a. Informant's Name/Retationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Md. 21221 Fern Gross / wife 3 Ridgemoor 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete N Burial 2 ☐ Cremation 3 ☐ Removal from State BelAir Memorial 7/11/98 BelAir MD. 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Service Licenses Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Cancer week Lung Due to (or es a consequence of): Physician/Medical Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Deeth 28d. Describe how Injury occurred 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 Neturat 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier edical (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) unner impleted cause of deeth (Item 23e) (Type, Print) 30. Name and address of person y 600 mo9000 Franklin Drive Square

State Registrar

Funeral

Director

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Pagas 1 and 2 should be filed within 72 hours aftar

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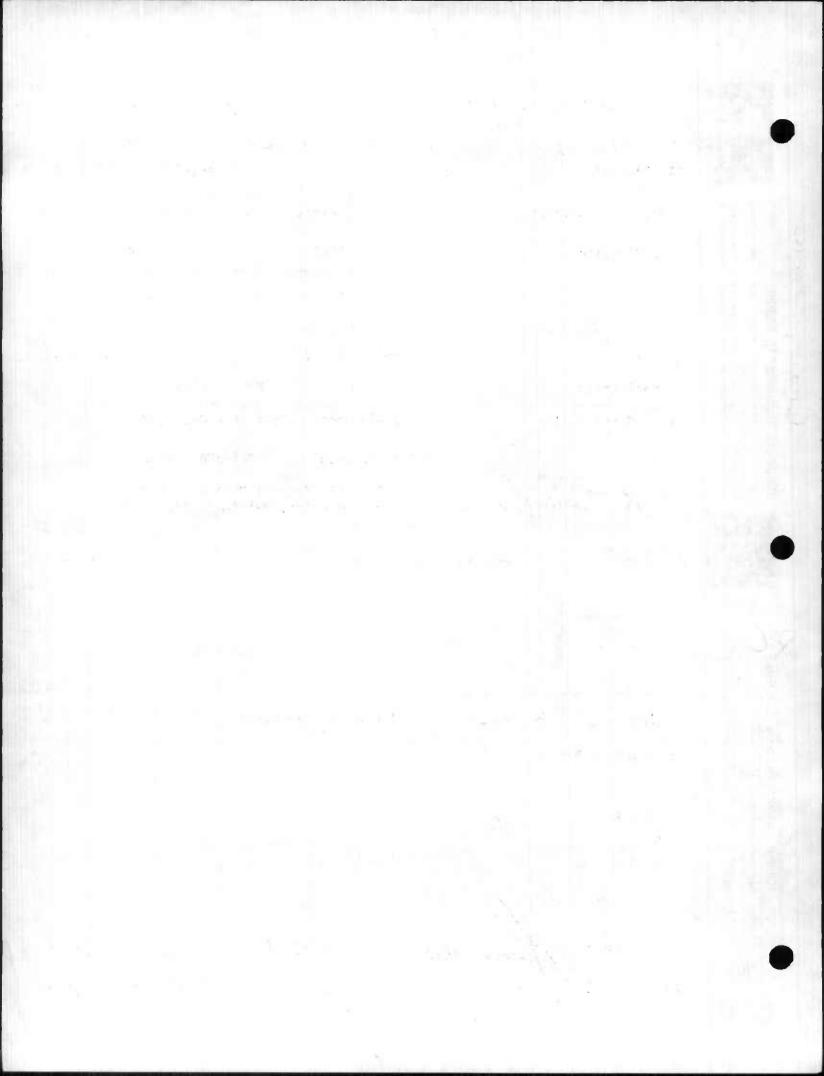
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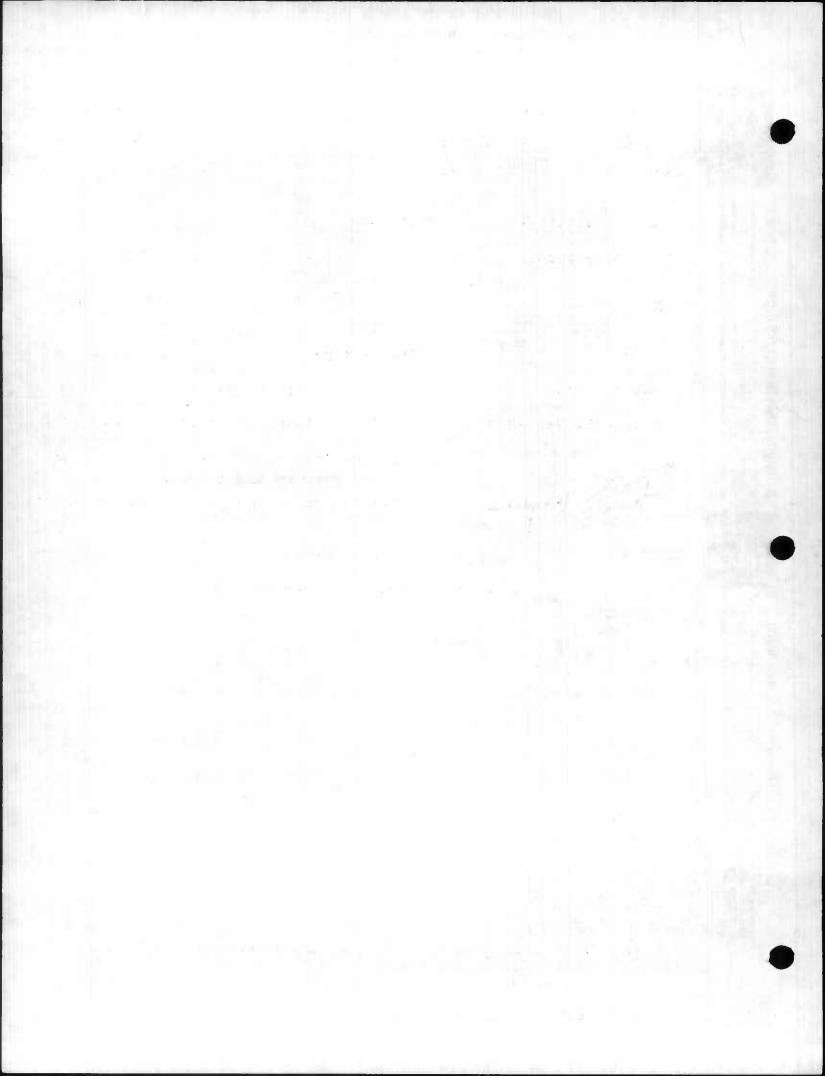
death.

Division of Vital Records, P.O. Box



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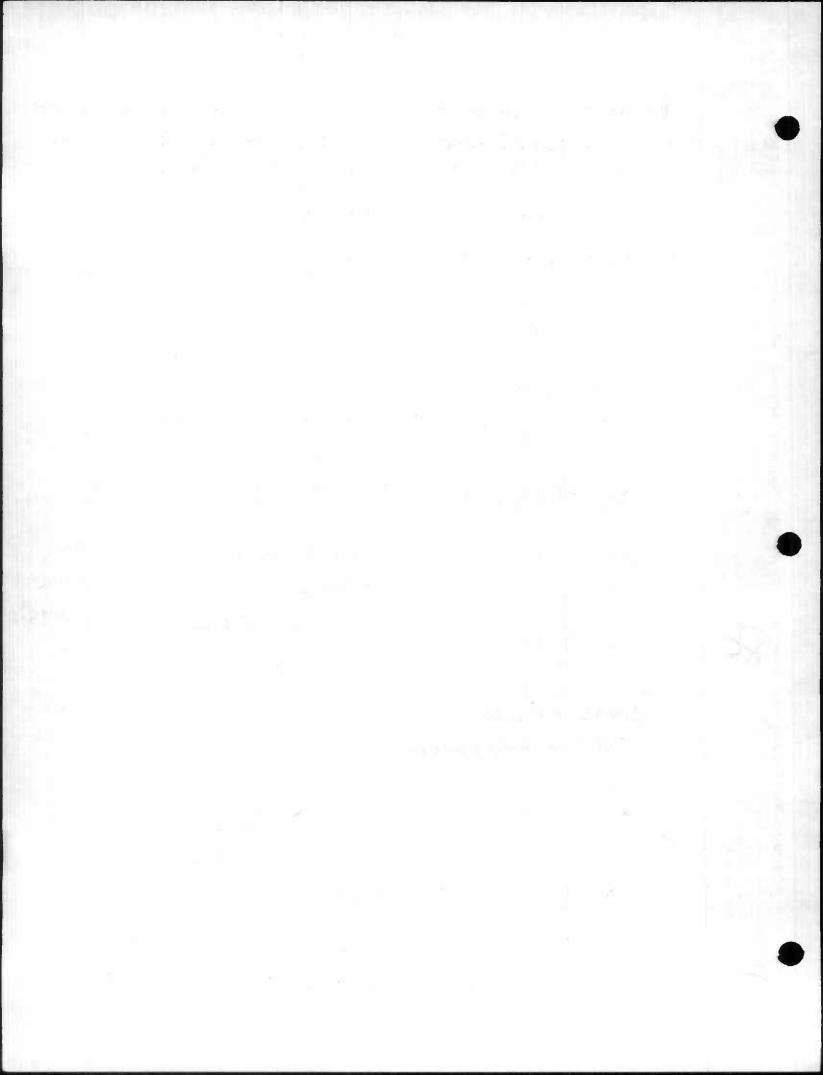
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LOUIS HARUE PR/1 '30 AH 6, /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartland Health Care Center Hvattsville Prince George's If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/17/59 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□ F Months Days 223-96-6335 38 Yrs. Director Virginia Usual Residence of Decedent 10e State 10b. Count 10c. City, Town or Location 28a-f ehow items 23a or 28a-f ehov 10d. Inside City Limits Director Prince George's 1 ☐ Yes 🎗 🛱 No Hvattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3302 Lancer Drive 20782 Funeral U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, event, the Modical Examiner Pages 1 and 2 should be filed within 72 hours effer onent of Haath and Mental Hygiena. Int: If Nem 27 ie marked other than "natural", or itei 1 Yes 2 No If Yes, Give Year or Detes: 1X Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 ☐ No by Specify: Afro American 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12+h Manager Int'l House of Pancake Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be traumatic Curtis Lee Harvey Gloria Calloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Haalth a : If Item 27 is or other tra Mrs. Gloria Jackson 3302 Lancer Dr. Hyattsville. Md. 20782 20b. Plece of Disposition (Name of cemetery, crematory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Frist St. Paul Church Cem. 5/1/98 Rustburg, Va. 21. Signature of Funeral Service Licensee per vr 22. Name and Address of Facility Joseph L. Russ 2222 W. North Ave. Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical immediate Cause (Final disease or condition resulting in death) **Examiner** The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or es a consequence of): Box 68760. NEUMONIA physician Physiclan/Medical Due to (or as e consequence of) signed by the e Division of Vital Records, P.O. Pert li. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco uas contribute to the causs of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown b Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? certificate has 1 Yes 2 No or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 20 No Hospital; 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes this After this 28d. Describe how injury occurred 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of Natural Accident Injury 5 Pending Investigation NA death. s after death.

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id in by the fu 1 Yes 2 No 3 ☐ Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completaly filled in Medical 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

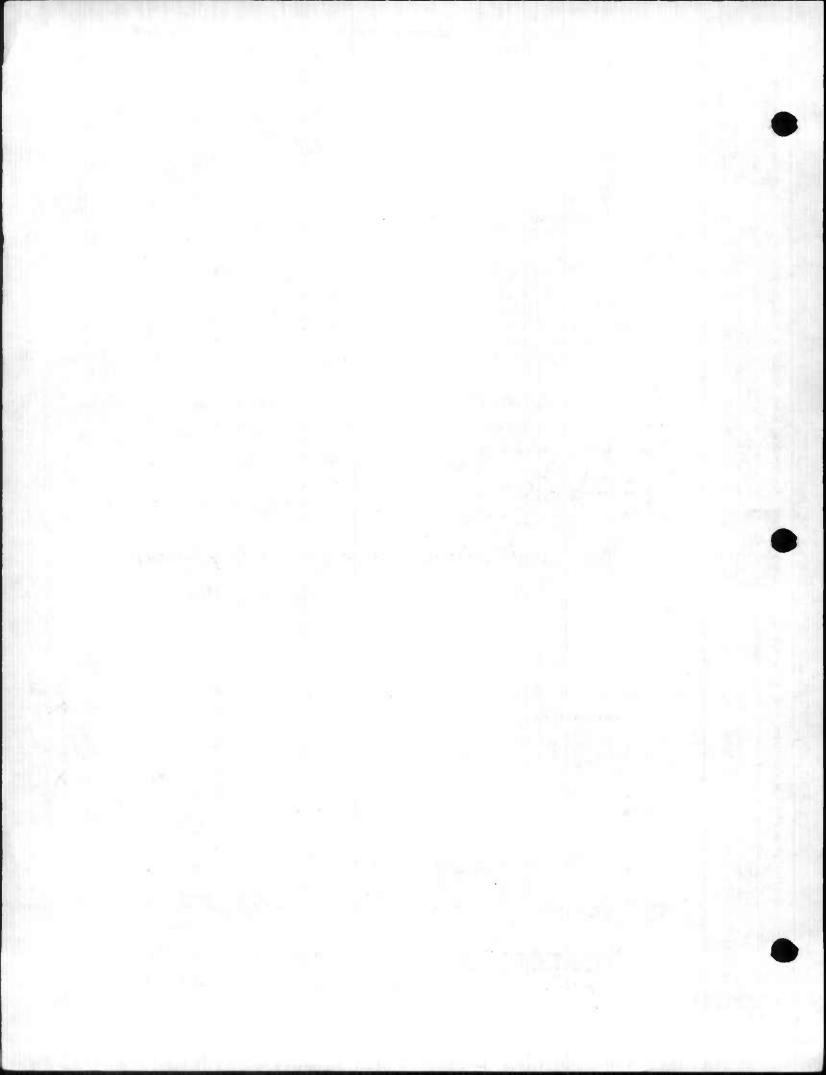
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) rsog who completed cause of death (item 23a) (Type, Print) 7 350 30 Name and address of o 12 Ris 32. Registrar's Signature (Month, Day, Year) State Registrar 1 0 1998

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Funeral Director	567-07-2710	ТМ 2ПЕ	ge (In yrs. 34	last birthday) Yrs.	If Under Months	Days	If Under 24 H Hours Mi	n. (Month, I	Sirth Day, Year) 21 1913	9. Birthplec Country, Virgi	e (State or Foreign nia
tang tang	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	ation					10d.	Inside City Limits
with the Maryland a or 28a-f show Lba notified at Director	WV Harriso	on	Cla	rksbur	g						1 ☐ Yes 2 No
or 28a-1 s be notified Director	10e. Street and Number				10f. Zip	Code			10g. Citizen of	What Country	?
Z2s Natth	102 Overlook Drive						301		USA		
if, or items 23a or 25a-f short transfeer must be notified at by Funeral Director	11. Marital Stetus 1 Never Merried 2 Merried 3 X Widowed 4 Divorced	12. Wes Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? [No	l lf	Ves Deced Yes, spec	ify Cuba	ispanic Origin? n, Mexican, Pui Specify:	(Specify Yes or I erto Rican, etc.)	Ble	ce - American ck, White, etc y: Whit	
	15. Decedent's Edu	cation		16a. Deced	ent's Usua	t Occup	ation	- 4 /	16b. Kind of B	usiness/Indus	try
other than 'nature went, the Medical. Be Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or	5+)	(Give I life. E	OO NOT us	k done i e retirec	turing most of w	rorking	1 - 79		
C Har	8	n/a		Produc	tion	Lin				k & De	cker
	17. Father's Name (First, Middle, Last)								le, Maiden Sumer	n <i>e)</i>	
To	J. W. Deel 19a. Informant's Name/Relationship (T)	vne Printl		19h Mailin	n Address	/Street		e OBenst	1aln aber, City or Town	State Zin Co	orle)
Transm.	Annabelle Johnson								g, WV 26		
lilem r othe	20a. Method of Disposition		20b. P	riece of Dispos	sition (Nan	ne of		10/98	20c. Location		, Stete
III Service	1 ☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		9	-				Çardens	Timoniu	m, MD	
mports any inju	21. Signature of Europat Service Licens	91		22.	Name an	d Addre	s of Fecility				1010
E 2 8	Michael J. Fla	21e					neral H nia Rd.		lum, MD 2	21093	
the burial-transit dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	arte		r as a consequence of as a consequence				1			
d by the attending physicial letached for use as the bur letached for use as the bur Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last	d	Due to (o	res a consequ	uence of):						
ed for	Part It. Other significant conditions cor	ntributing to death	but not resi	ulting in the un	derlying c	ause giv	en in Pert t.	23b. Di	d tobacco use co	entribute to th	e cause of death
2 2	Dementio							- 11	Yes 2 No	3 Probet	ly 4 Unknow
should should									as an autopsy rformed?	availa	autopsy findings ble prior to letion of cause ath?
paga 2								10	Yes 20KNo	1 U Y	es 2 No
ector Be	25. Wes case referred to medicat examiner?	deschel:				Lou		eath (Check on)	y one)		
를 들	1 Yes 2 No	Hospitel:		ER/Outpatient			4 modanising		sidence 6 Ott		
or: After the funa cation	27. Manner of Death 1 ÉNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of In (Month, D		28b. Time of tnjury	М		yat k? Yes 2□No		e how injury occu		
rei Direct illed in by Certiff	4 Homicide determined		tc. (Specif	v)				City or 1	(Street and Num. Fown, Stete)		
To the Funeral Dir completely filled in Medical Cer	29a. Certifier 1 € Certifying Physical Check only one) 2 Medical Examination		of examine								
To the	29b. Signature and title of certifier				290	Licens	number		29d. Date signe	ed (Month, Da	y, Year)
,	Marin Ka	valur a	<u>. </u>				21022		7-7-	98	
0	30. Name and address of person who co M. C. /CUW A LET 31. Date filed (Month, Day, Year)	empleted cause of	death (tterr	1 23a) (Type, F	Print)						
	/4. (/ // 000			, , -, , , , ,	- V		-	0/1 40		6	



Please Type or Print in Black indelible lnk. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) DeyrH MOSNHOE 8:25 AM 1998 EORGE JULY 07 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth PALTIMORE. RANDALLSTOWN CENTER: HOSPITAL NORTH WEST If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) Months Deys Hours Min Yrs. Md 213-16-6710 6 -23-1921 Usuel Residence of Decedent 10c. City, Town or Location 10a Stete 10b. County 10d. Inside City Limits Baltimore 1 Yes 2 No NA Ma 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? U.S.A Royal Garden 2007 21207 Drive Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Bace - American Indien. 11. Maritel Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Black 1 Yes 20 No Specify: Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Elementery/Secondery (0-12) Coilege (1-4or 5+) haborer Steel 8th grade NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) E. George Johnson Henrietta Hamson 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) "2//33 Randallstown, rul oal Buchanan - Daughter 3839 Brook Jan Mary Duc 20a. Method of Disposition 20b. Piece of Disposition (Name of cometery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Battimore, nd Cenetery Ridge 7-11-98 21. Signature of Fungert Bervice Licensee 2. Neme and Address of Facility 2/2/5 1807 Wabash Grenue 300 recle 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete intervel Between Onset end Deeth immediete Ceuse (Finel diseese or condition resulting in deeth) FULL BENT SEVENdos ACUTE CEREBROVASCULAR Due to (or es e consequence of): Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown AIMOMUSING 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? MELLITUS. 1 Yes 2 No 1 Yes 2 Vo 26. Place of Deeth (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 5 Pending investigation 1 Yes 2 No

Examiner Box 68760 Division of Vital Records, P.O. 20 B Ä page 2 is certificate h director, page Ħ funeral or Attending death. within 24 hours after death To the Funeral Director: completaly filled in by the

Physician

/Medical

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

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Examiner

Physician/Medical

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Completed

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Certification:

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Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manylar Department of Heelth and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic avent, the Modical Examiner must be notified at once.

RILATERAL DIABETES 25. Wes case referred to medical exeminer? 1☐ Yes 2 No 27. Manner of Deeth 1 Neturei 2 Accident 6 Could not be determined 3 Sulcide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 156 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) end menner stated.

29a. Certifier (Check only one) 29b. Signature and title of certifie

4 Homicide

MARICINA HOUSE

29c. License number D 42723 .

29d. Date signed (Month, Day, Year) JULY 07

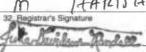
30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) HARISH HVVERAKOZLI

FORFORD STREAM BALTIMORE 21236

State Registrar

31. Dete filed (Month, Day, Year) JUL 1 0 1998

ana



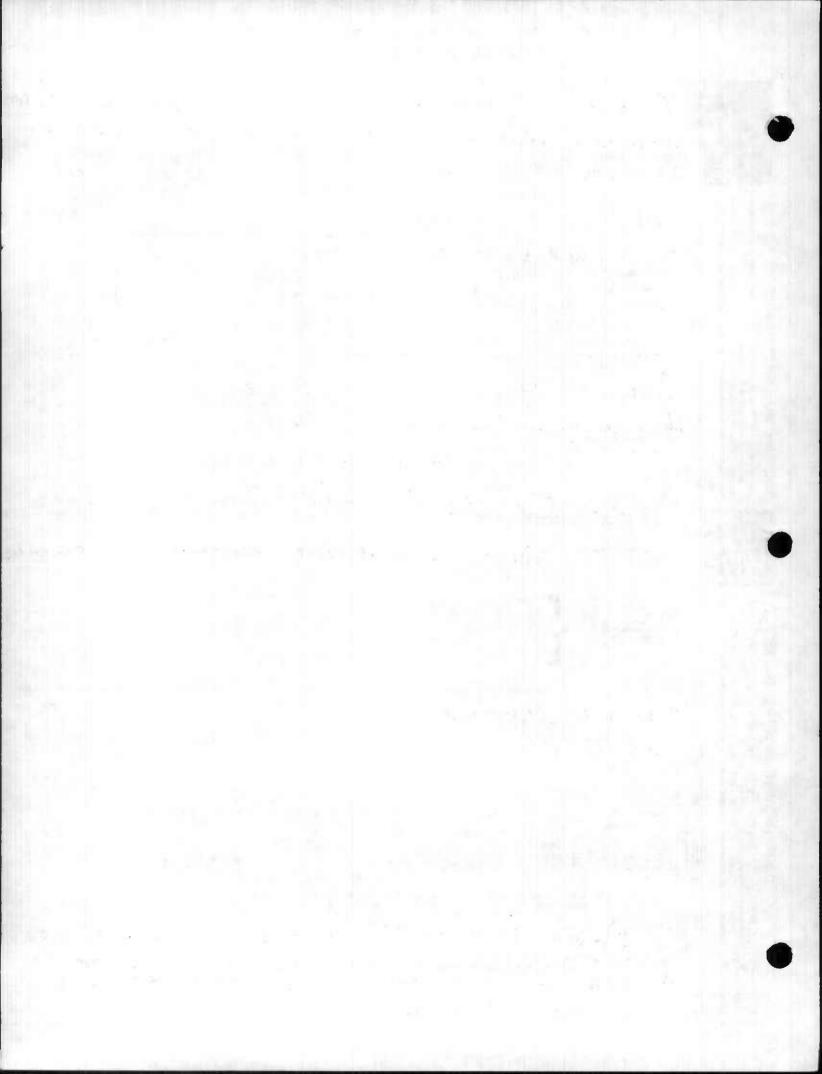
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

DHMH 16 Rev 6/95

Hospital

To the Within 2

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

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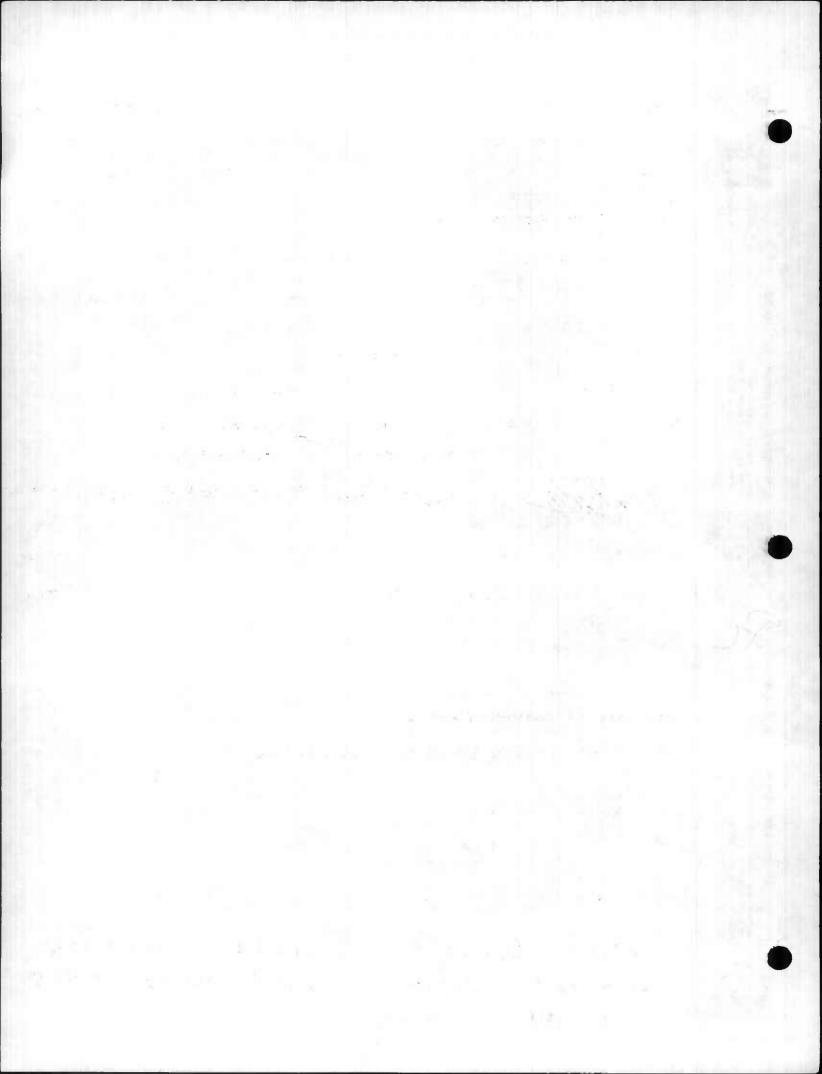
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Funeral Director	5. Social Security Number 6. Sex 1 M	7. Aga (In yrs. lest b	irthdey) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Dey,)9-07-1		9. Birthplace (State or Foreign Country) Korea
pu &	Usuel Residence of Decedent 10a. State 10b. County	10c City To	wn or Location				10d. Inside City Limits
e Maryla ta-f shortified at	MD Prince Geor		ellville				1 ☐ Yes 2 ☐ No
Office the Main the Main the Main the Main the Main the Main the motified material Director	100. Street and Number 10706 Lake Arbor Way	7	10f. Zip Code 20721		10	usa USA	hat Country?
Dy 1.0	1 ☐ Never Married 2 🔀 Married	Vas Decedent Ever in U,S. med Forces? □ Yes 2∰No Yes, Give ear or Dates:	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 No	ispenic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	Bleck	- American Indian, , White, etc. Korean
21215-0 ed within 72 hor sygiena. ser than "natura rt, tra weatral Completed	15. Decedent's Educatio (Specify only highest grede cor		a. Decedent's Usual Occup	ation during most of working		16b. Kind of Bus	iness/Industry
21 Ban r	Elementery/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	n			
d 212 filed withi Hygiena. ort, tre M	12		Housewife		F . 18:44- 1	Own Ho	
Maryland d 2 should be flie th and Mental Hy 7 is marked othe traumatic event To Be (17. Father's Neme (First, Middle, Last)			18. Mother's Name (raiden Sumeme	y
hould a Menidan marken	Hoon Hwang 19a. Informent's Neme/Reletionship (Type, I	Orint) 10	b. Mailing Address (Street	Gan Nar		City or Town 5	State Zin Code)
Mar d2 sho th and 7 is m traum			3 Almanac Ct.				, L. () 0000/
re, N 1 and Health tem 27	20a. Method of Disposition	20b. Plece	of Disposition (Name of ery, cremetory or other place			MD 20c. Location - 0	City or Town, State
Baltimore, pemir. Pages 1 a Department of Her Important: If item any injury or othe once.	1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from Stata Meadov	vridge Memori	al Park 7-	-6-98	Elkridge	e, MD
Departing any in portion	21. Signaturo Funda Service Licensee	ura A. Dexte	Cary L. Kauf 7250 Washing	man Funera Jton Blvd.	al Home Elkr	at Maed	dowridge Mem Pa MD 21075
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	SEPSIS Due to (or as	a consequence ot):	ng, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
nsit nin	b	Prec mo					Lacys
r 68760, ntilicate to executed as the burlat ransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest		a consequenca of):				
Box attendin for use	d						
S, P.O. BOX as that the death cert igned by the attending be detached for use a by Physician/M	Part II. Other significant conditions contributions of the conditions contributions of the conditions		A THE SECOND SECOND				tribute to the cause of death? 3 Probably 4 Unknown
ecord aw requir ts been s 2 should	ANTEMOLUEN	one CANSI	Y OVASCULUR	Disease	24e. Was e		24b. Were autopsy findings evalleble prior to completion of cause of death?
The The Page					1□ Y	s 2 No	1 ☐ Yes 2 No
Vital Files The cartificata rector, pag	25. Was case referred to medical examiner?			26. Plece of Death	Check only on	е)	
Of Vital Physician: T this cartificat ral director, pr	1 Yes 2 No Hosp	1 Aunpatient 2 LER/C		4 LI Nuising Florin			
ding Pt After th funera		(Month, Dey Yeer)	Time of 28c. Injury Wor	y et rk? Yes 2 □ No	3d. Describe ho	ow Injury occurre	bed
Division of Vital Re To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this cardificate he completely filled in by the funeral director, page Medical Certification: To Be Com	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 2	Be. Placa of Injury - At home, building, etc. (Specify)			Bf. Location (Si City or Town	reet end Numbe n, Stete)	er or Rurel Route Number,
he Hospital in 24 hours he Funeral pletely filled edical C	(Check only 2 Madical Examinar:	n: To the best of my knowled On the basis of examinetion e and manner stated.					
To the within To the comp	29b. Signature and title of cartifier	Woreho	29c. Licens				(Month, Dey, Year) 3 1998
3	30. Name and eddress of person who complete A . BEV C	RE MD 4					18106011
State Registrar	31. Dete tiled (Month, Day, Year)	32. Registrar's Signature	son-Randell				- Y 1
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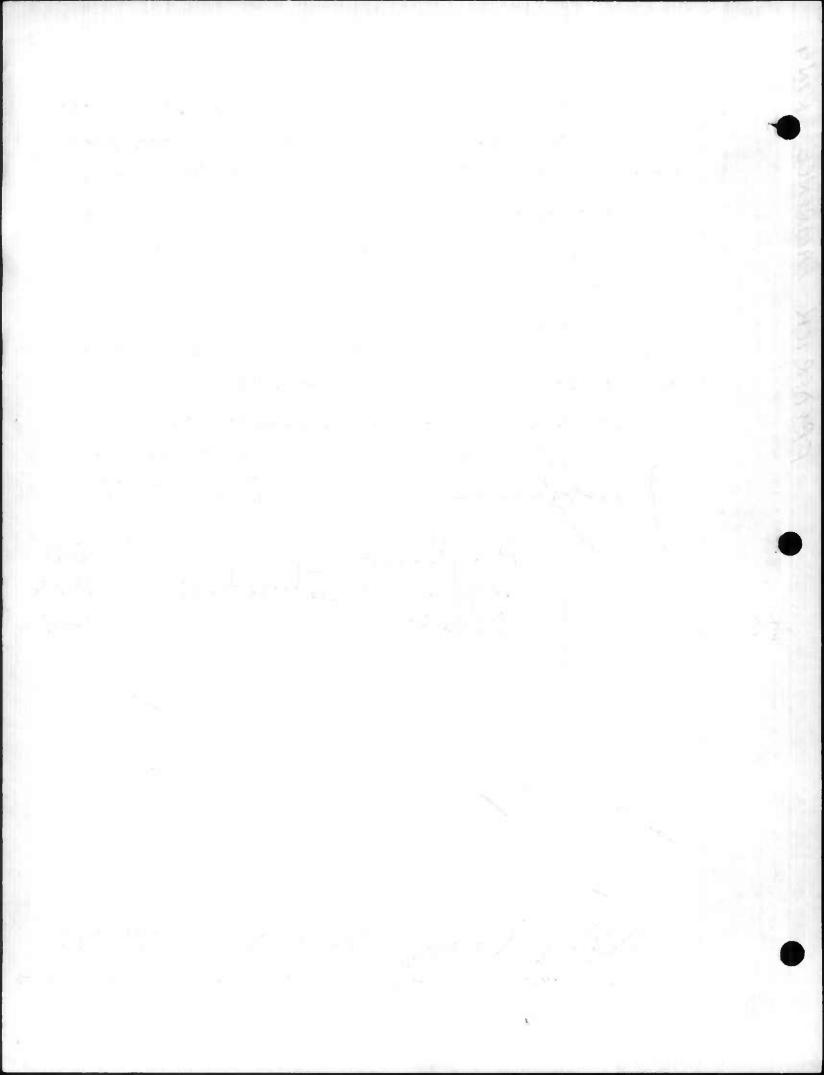
State of Maryland	Department of Health and Mental Hygier	ıe
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vsician	Decedent's Name (First, Middle, L.)	204)		Cen	ificate of	Death	2. Dete of Dee	Reg. No.		
ysician	Frederick Lawren						Month	Day	Yeer	3. Time of Death
Medicai	4a. Facility Name (If not Institution, gi					4b. City, Town, or I	JULY	6, 1998		12:15 A
aminer	DOCTORS COMMUNI	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s					Location of Death			
			ge (In yrş. la	st birthday)	If Under 1 Year	LANHAM If Under 24 Hrs.	8. Date of Birt		OE GEO	
erai etor	578-50-1200 Usual Residence of Decedent	Sex 7. Ag 11 M 2 F	59	Yrs.	Months Deys		8. Date of Birt Month, Dat Aug. 28	, Year 938,	Count Maryla	ace (State or Foreig ry) and
55	10a. State 10b. County		10c. City,	Town or Loc	ation				10	d. Inside City Limits
to	MD Prince G	George's	Lanh	am						Yes 2□No
irec	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Count	ry?
<u>e</u>	7703 Cross St.				20706			U.S.A.		
once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 244 If Yes, Give Year or Dates:			as Decedent of Yes, specify Cul	Hispanic Orlgin? (S ban, Mexicen, Puert Specify:	pecify Yes or No- o Ricen, etc.)	14. Rac Blac Specify	ce - Americe ck, White, e Whit	tc.
Completed	15. Decedent's E (Specify only highest gi	Education		16a. Decede	nt's Usuai Occu	upation a during most of wor ed)	kina	16b. Kind of B	usiness/Indi	ustry
npidu	Elementary/Secondary (0-12)	College (1-4or :	5+)			ed)		D41	1 M1	.1.
S	8			La	borer	Tillian		Tile and		ote
To Be	17. Father's Name (First, Middle, Las Carlton C. King	•				Isabel M	ne (First, Middle, leddings	Maiden Suman	ne)	
F	19a. Informant's Name/Relationship	_		19h Malling	Address (Stree	at end Number or Ru		r City or Town	State Zin	Code)
	Eileen M. King/w					. Lanhan		706	State, Zip t	ovde)
40.3	20a. Method of Disposition	VIIC			ition (Neme of atory or other ple		Date	20c. Location -	City or Tov	vn, State
	1 X Buriel 2 ☐ Cremation 3 0 4 ☐ Donetion 5 ☐ Other (Spec				1n Ceme	tery 7	/9/1998	Brentwoo	od, MI)
ė	21. Signature of Funeral Service Lice			22.	Name and Addr	ress of Facility D.C.	bert E.	Evanc 1	Funor	1 Home
KIIKE	James	Ann-				apolis Rd		ie. MD	20715	
	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused	d the death.			-				
	snock, or heart failure./ List only	y one cause on each li	ne.							Approximete Intervel Between Onset end Death
ıl 🔠	Immediate Cause (Final	ACI	tur	KOW	114					mins
	disease or condition resulting in death)	a. 1011	Due to (or e	s a consequ	ence If):	-	1.			1001100
iner	_	. M	1000	mol	0	wter	ctia			MING
Examiner	Sequentially list conditions,	~	Que to (or a	a consequ	ence of):		C 1 -0			1-
E H	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	10	ab _e	160						Year
edical	thet Initiated events resulting in death) Last		Due to (or a	is a consequ	ence of):					•
150		d								
clar							1 20 20			
Physician/	Part II. Other significant conditions	contributing to death b	ut not result	ing in the und	derlying ceuse g	iven in Part I.		-/		the cause of death
by P							1 1	700 2 NO	3 Prob	ably 4 ☐ Unknow
Completed b								an autopsy med?	ava	re autopsy findings llable prior to apletion of ceuse eath?
ם								/		
	OF Mes sees referred to medical						1 U Y		10	Yes 2□ No
	25. Was cese referred to medicel examiner? 1 Yes 2 No	Hospital:		210	00 000	ther	th (Check only o			
o Be	27. Menney of Death	1 Inpatie	ry 2	R/Outpatient 8b. Time of	28c. inju	ury at	ome 5 Resid	12.00		,
2		(Month, Da	y Year)	Injury		ork?]Yes 2∐No				
2	1 Netural 5 ☐ Pending investigation		unr - At hom	e, farm, stree	et, factory, office		28f. Location (S City or Tow		per or Rural	Route Number,
2		A ZOU. PIUCU OI INI	c. (Specify)							
Certification: To	2 Accident investigation 3 Sulcide 6 Could not to determine to	building, etc	c."(Specify)	adne death	occurred at the t	ime dete and place	and due to the	euse(s) and ma	anner as etc	ated
Certification: To	2 Accident 3 Sulcide 4 Homicide 29a. Certifier 29a. Certifier	A ZOU. PIUCU OI INI	c. (Specify) of my knowled exemination	edge, death on end/or inve	occurred at the t stigation, in my	ime, dete end place opinion, death occu	, end due to the c rred et the time, c	ause(s) and madate and piece,	anner as sta and due to	ated. the cause(s)
2	2 Accident 3 Sulcide 4 Homicide 29a. Certifier (Check only) 2 Medical Exa	building, etc. hyalcian: To the best of	c. (Specify) of my knowled exemination	edge, death on end/or inve	stigation, in my	ime, dete end place opinion, death occu se number	rred et the time,	eause(s) and ma date and plece, 29d. Date signe	and due to	the cause(s)
Certification: To	2 Accident 3 Sulcide 4 Homicide 29a. Certifier (Check only one) Check only one)	building, etc. hyalcian: To the best of	c. (Specify) of my knowled exemination	edge, death on end/or inve	stigation, in my	opinion, death occu	rred et the time,	date and plece,	and due to	the cause(s)
Certification: To	2 Accident 3 Sulcide 4 Homicide 29a. Certifier (Check only one) Check only one)	hyalcian: To the best of miner: On the basis of and manner sta	of my knowled exemination ated.	n end/or inve	stigation, in my	opinion, death occu	rred et the time, d	date and plece,	and due to	the cause(s)

Registrar

JUL 1 0 1998

Julia Varidson-Randesse



State of Maryland / Department of Health and Mental Hygiene Item 10b per Fh Film G761 7-22-98 rja Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth **Physician** Month 12:15 M REGINA F. 2, JULY 1998 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociei Security Number 9. Birthplece (State or Foreign Country) POLAND 7. Age (In yrs. last birthday) **Funeral** Deys 1 □ M 2 F 213-20-7790 72 Vre Director Usuel Residence of Decedent the Marylend Show 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "nature!", or frems 23a or 28a-f show treumstic event, the Medical Examiner must be notified at Cecil 1 ☐ Yes 2 No Director HARFORD CONOWINGO 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? with 1 22 BLUFF DRIVE 21918 U.S.A. deeth Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indien, Bieck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer c Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or herr any Injury or other traum-size. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. ρ Specify. 3 ₩Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 MANUFACTURING VULCAN HART 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) **JOSEPH** FAJKOWSKI un known 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Straet end Number or Rural Route Number, City or Town, Stete, Zip Code) EUGENE A. KELLY / SON 22 BLUFF DR. CONOWINGO, MD. 21918 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) STAINSLAUS CEME. 7/6/98 BALTIMORE, MD. 21. Signature of Funerel Service License 22. Name and Address of Facility KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222 uger artho 23e. Pert1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear feliure. If st only one cause on each line Approximete Intervel Between Onsel end Deeth **Physician** /Medical 4 Days Immediate Ceuse (Finel e. Respieutory Ca disease or condition resulting in death) Examiner Examiner Abdominal April Aneusym physicien and the buriel-trensit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Box 68760 Physician/Medical Due to (or es e consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 D tinknown by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 Tyes 2 No Division of Vital or Attending Physician: effer death. Director: After this certific 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitai: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No funeral c 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Naturel 28f. Location (Street and Number or Rural Route Number, City or Town, Stetp) 1 Yes 2 No 2 Accident NA JA 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours e To the Funerei D NA Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 7-2-98 D15502 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) HDG, MD 21078 433 Sinal MD 5+. JesAdA 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Julian Tavidson-Randall Registrar JUL 1 0 1998

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day **Physician** Mervin С. July 6, Knocke 1998 1:08 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North Arundel Hospital Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) 6, 1932 6. Sex 1 Ø M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Yrs 505-36-0818 65 Director Nebraska Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 눕 8063 Green Orchard Rd. 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (2) Yes 2 | No 1952 If Yes, Give Year or Detes: 1977 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status pemit. Pages 1 and 2 should be filed within 72 hours eiter Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or he eny injury or other treumatic event, the Medical Examinations. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: P 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Military US Air Force 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 John S. Knocke Doris McMannon 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicky L. Ingram (Daughter 8026 Hadfield Ct. Pasadena, Md. 21122 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Metro Crematory Inc. 7/9/98 Baltimore Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Lie 22. Name and Address of Facility Stallings Funeral Home PA and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, asset of each line. Md. 21122 Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner MUS MOLA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 ž Due to (or as e consequence of). signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause 23b. Did tobacco use contribute to the cause of death? gwan in Part I 1 Yes 2 No 3 Probably Dunknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 1 Yes 2 No Hooptal or Attending Physician:
 124 hours after death.
 Funeral Director: After this certifical death filled in by the funeral director. 89 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) 1 Ves 28 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 22 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 2 Accident investigetion 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier 1 Complying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tyle of certified 29c. License number 29d. Date signed (Month, Day, Year) D43789 July 7, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William L. Hunter Jr. MD 1132 Annapolis Rd. Odenton, Md. 21113 31. Data filed (Month, Day, Year) 32. Regiştrar's Signature

DHMH 16 Rev 6/95

Registrar

JUL 1 01998

-gandale

Julia Davidson

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month Year RITA STELLA LOHINSKI JULY 1998 1:25 PM 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Death GENESIS ELDER CARE AT HAMILTON BALTIMORE N/A If Under 24 Hrs. 8. Dete of Birth (Month, Dev. Year) 4/26/13 If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) MD . 7. Age (In yrs. lest birthday) Months Deys 1 □ M 250 F 215-10-4302 85 Yrs. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 □ No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whef Country? 6 N. POTOMAC ST. .1224 U.S.A. 12. Was Decedenf Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 1 Never Merried 2 ☐ Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 8 SALES 0 SALES CLERK 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) STELLA WILLIAM LOHINSKI BRUKIEWA 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) BERNARD LOHINSKI 524 N. CHARLES APT. 408 BALTO., MD. 21201 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 1 ■ Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) STAINSLAUS CEME. 7/8/98 BALTIMORE, MD. 21. Signeture of Funeral Service Licansee KACZOROWSKI FUNERAL HOME P.A. lei 1201 DUNDALK AVE. BALTO. , MD. 21222 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of) Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Pert I 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown teoporosis 24b. Were autopsy findings avellable prior fo completion of cause of death? 24e. Wes an autopsy Fracture of Vertebrae 1 Yes 2 No 1 Yes 2 No 26. Pleca of Deeth (Check only one) Hospital:

Physician /Medical Examiner

permit. Pages Department of Important: If It any Injury or o

Physician

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Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental hygiene.
Int: If Item 27 I a marked other than "natural", or Items 23s or 23s-f show uny or other transmit be notified all my or other transmit be notified at my or other transmit be notified at

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed Be To

Certification:

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Affending after death Director: 24 hours Funeral

Division of Vital Records, P.O. Box 68

State Registrar

25. Wes case referred to medical exeminer? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatienf 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 1 Netural 5 ☐ Pending 1 Yes 2 No investigation 2 Accident 8 Could not be determined 28f. Location (Street and Number or Rurel Roule Number, City or Town, Stete) 3 Sulcide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. (Check only one)

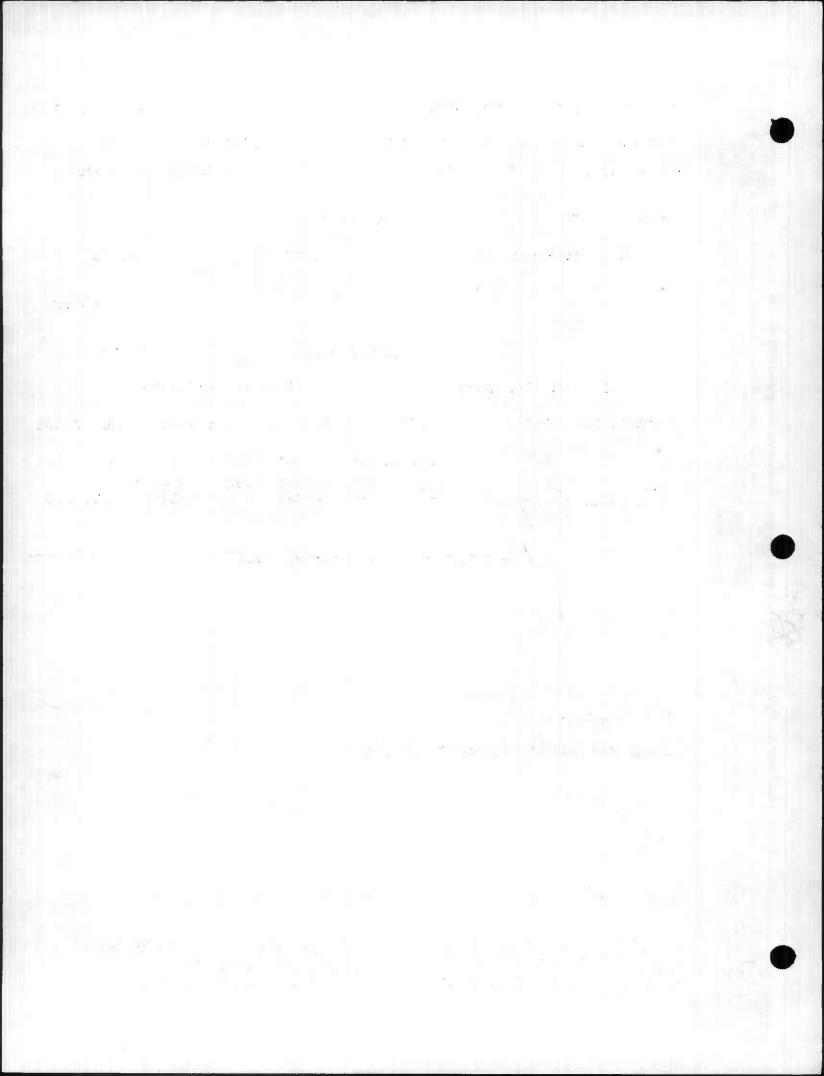
29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of cartifier 29c. License number

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Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 703 S. Clinton St SHCI futi PATRICIO Baffimore, Md 2122+ to

31. Dete tiled (Month, Dey, Year) JUL 1 0 1998 32. Registrer's Signeture Johia Davidson

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

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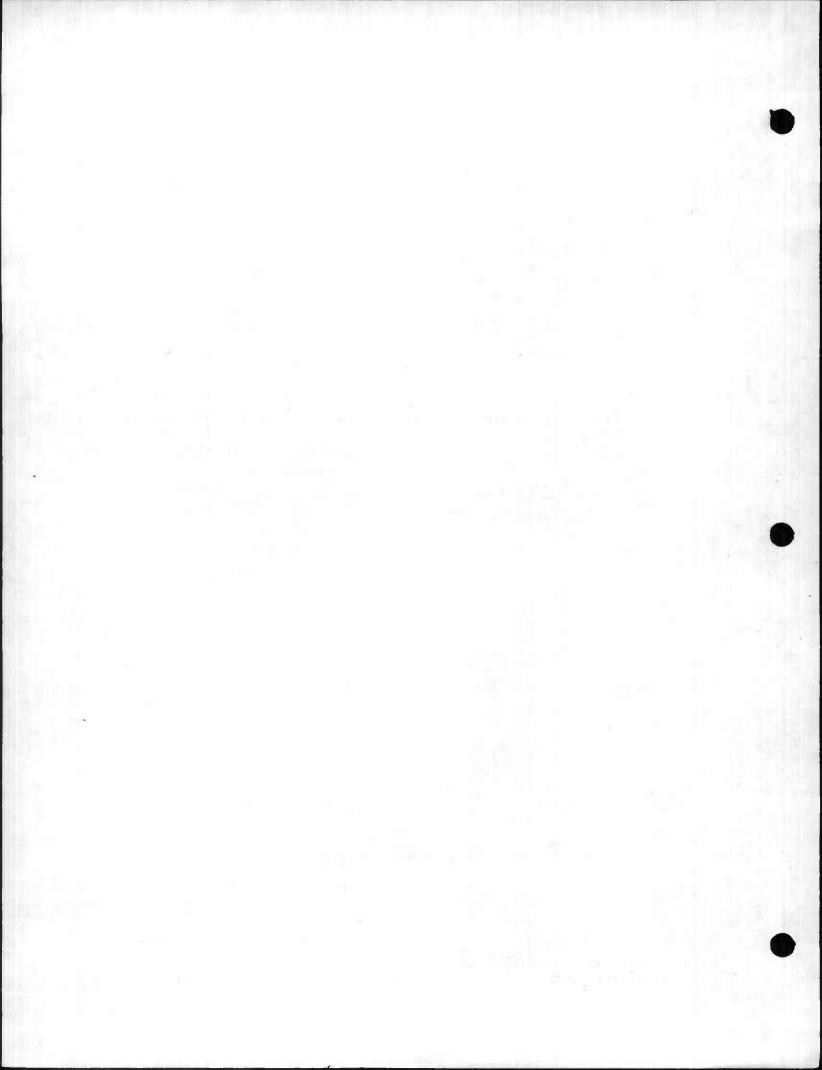
Baltimore, Maryland 21201

TWO BOXES

State of Maryland / Department of Health and Mental Hygiene 21239 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** July 5, Musacchio 1998 Sandra 4:30 am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3075 Chestnut Hill Drive Ellicott City Howard | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 5, | 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 N F Months 51 Yrs. 235-74-9066 Director Usuet Residence of Decedent 10s State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Howard Ellicott City 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 3075 Chestnut Hill Drive 21043 238 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Remail Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be Illed within 72 hours after which of Health and Metall Hygians.

Anti Il Item 27 is merked other than "natural", or the surface or other training to cope training event, the Medical Examina 1 Never Married 2 X Married Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Commerical 12 Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glen Helmick Norma Eichelberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent Musacchio / Husband 3075 Chestnut Hill Drive, Ellicott City, Md. 21043 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: If Ite any Injury or of 1 XBurial 2 Cremetion 3 Removal from Stete Sugarlands Cemetery 7/10/98 Davis, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) atum of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical METASTATIC GREAST Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or as a consequence of): The law requires that the death certifical Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen page 2 1 Yes 2 No 1 □ Yes 2 □ No certificate of Vital Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? Division al or Attendenth. After 1 Neturet 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital e within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number 7/8/98 MA S18320 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Ducology CESTER Battinone MS 21287. John Fetter MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature Mia Davidson-Randelle Registrar



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Yes 2 No yone) sidence 6 Ot be how injury occur of (Street end Num fown, Stets) ne cause(s) and me, date and place	pontributa to the available complet of death 1 Yes ther (Specify) and due to the available complet of death 1 and due to the available complet of death 1 and due to the available complet of death 1 and due to the available complete of death 1 and due to the available complete of death 1 and due to the available complete of death 1 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and due to the available complete of death 2 and	cause of death? Cause of death? Alphnowr utopsy findings e prior to ion of cause ? Land Number, cause(s)
	23e. Part1 Ente shock, or he shock, or he tempediate Ceus disease or cond resulting in deat sir any, leading to cause. Enter Ut Cause (Disease that initiated ever resulting in deat sir any). Part II. Other aig CAC. 25. Wes case re examiner? 1 Yes 2 27. Manner of De 1 Manner of De 1 Manner of De 1 Manner of De 1 Manuel 2 Acciden 3 Suicide 4 Homicide 29a. Certifier (Check only one)	er the disease, or content failure. List only se (Finel itilion h) conditions, immediate deriving or injury ints h) Lest HEXIA ferred to medical No seath 5 Pending investigating of Could not determined to determined.	hysician: To the basiness: On the basiness:	Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a Due to 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Plece of Other: 4 Nurs Injury at Work? 1 Yes 2 Notice	rdiac or respiratory STASIS 23b. DI 10 24a. Wi pe 15 10 10 10 28f. Location City or 7 Dlace, and due to It occurred at the time	TO LUNC Id tobacco use co Yes 2 No as an autopsy rformed? Yes 2 No yone) sidence 6 Ot be how injury occur of (Street end Num fown, Stets) ne cause(s) and me, date and place	App Inter Ons Ons Ons Ons Ons Ons Ons Ons Ons Ons	cause of death? Cause of death? Alphnowr utopsy findings e prior to ion of cause ? Land Number, cause(s)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

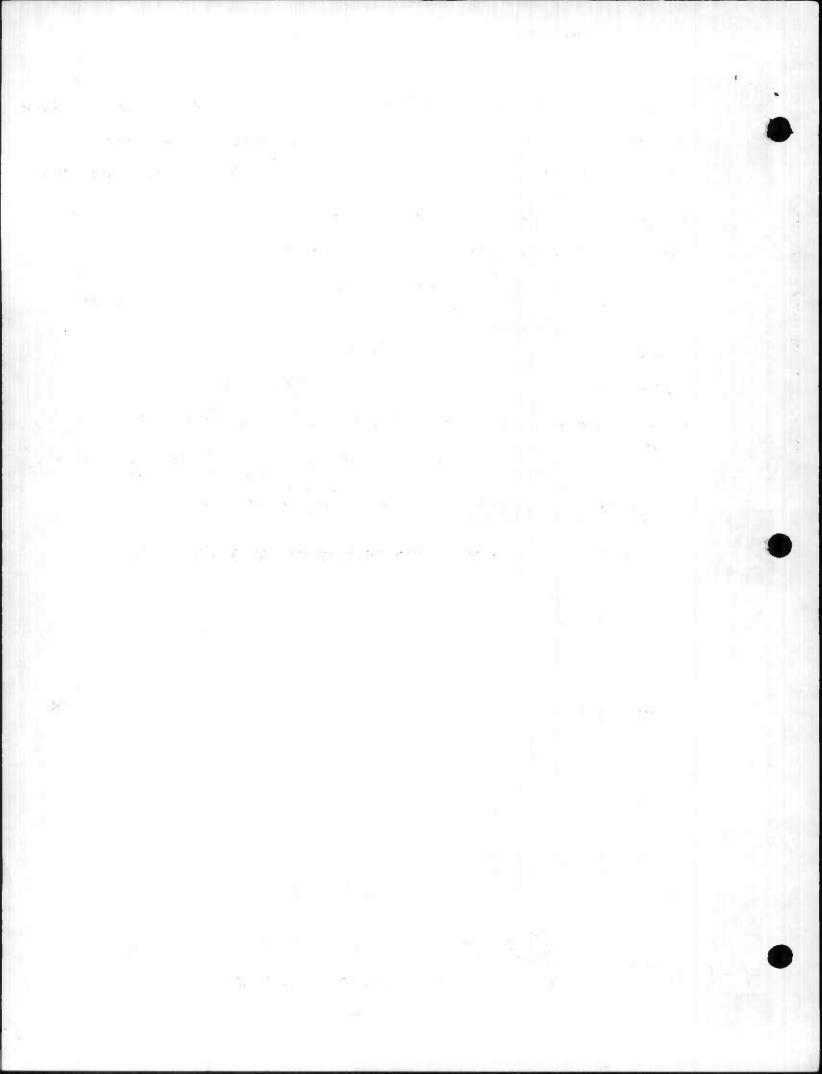
BALA DUGGIRALA, MD., VA MEDICAL CENTER, FT. HOWARD, MD 21052

JULY 3,1998

State Registrar

31. Date filed (Month, Dey, Year) 1998



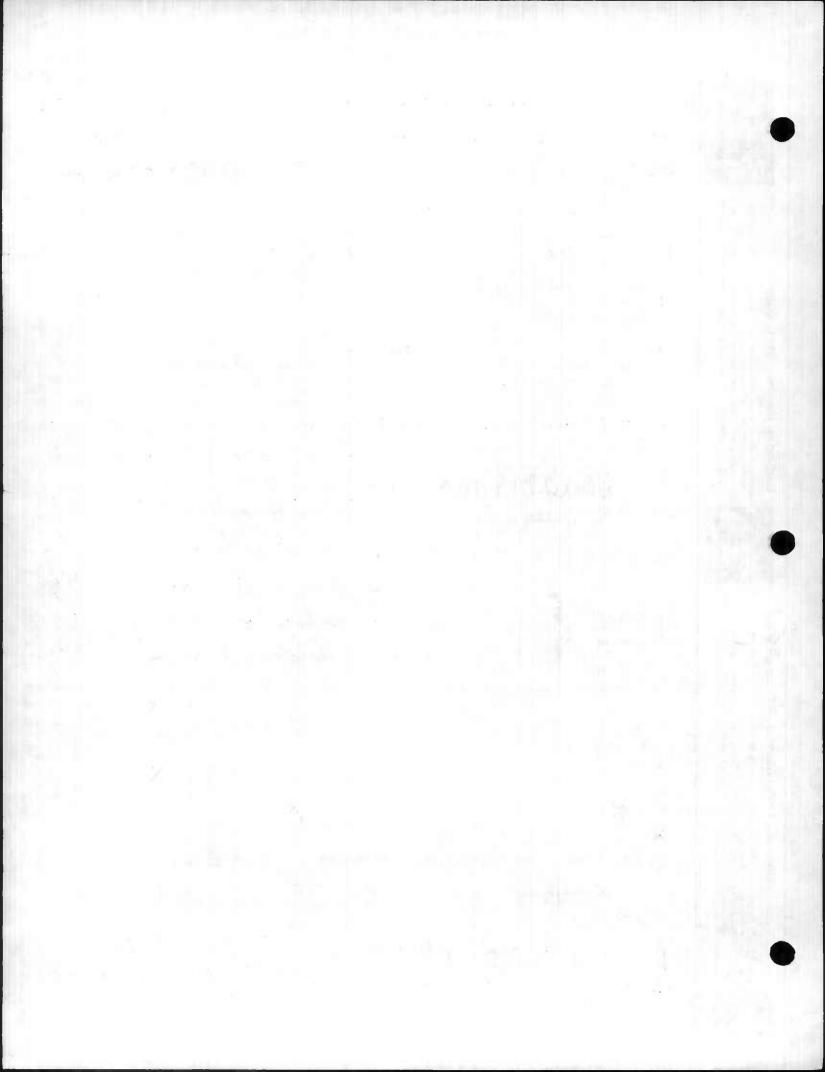


State of Maryland / Department of Health and Mental Hygiene

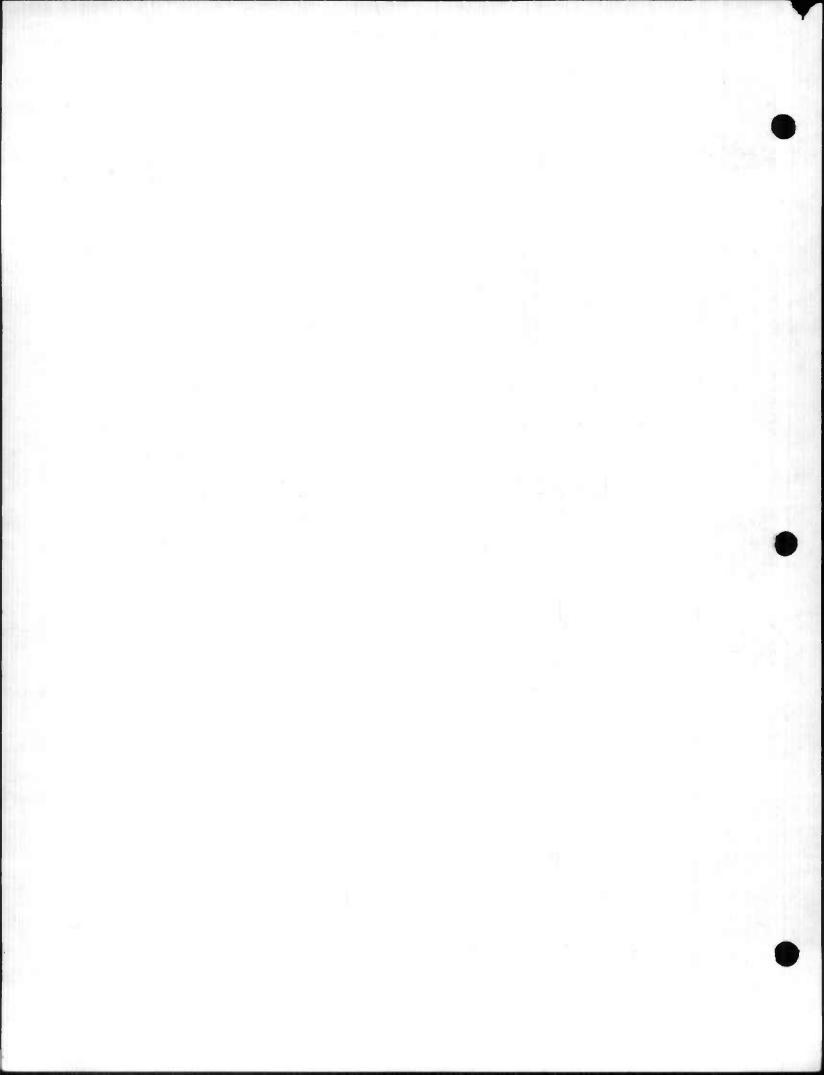
98	0	10	1
20	2	16	17

		Certificate of Death	h Re	g. No. 30 2124
	Decedent's Name (First, Middle, Last)		2. Date of Death	
Physician /Medical	Frances Droce	ella Merson	JULY	8, 1998 5:30pi
Examiner	4a Facility Name (If not institution, give street end number)		Town, or Location of Death	4c. County of Death
	Rock Glen Nursing & Rehab.	. Center Ba	ltimore	N/A
neral	Social Security Number 6. Sex 7. Age (In yrs.)	lest birthday) If Under 1 Year If Und Months Days Hours	ar 24 Hrs. 8. Data of Birth Min. (Month, Dey,	Year) 9. Birthplace (State or Fore Country)
ctor	212-12-2945 1 ¹ M 37 F 98	Yrs. Month's Days Hours	JAN 17.	1900 Maryland
	Usual Residence of Decedent			•
rector		y, Town or Location		10d. tnslde City Lim
Director	MD N/A	Baltimore		X□ Yes 2□
1 5	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
<u></u>	714 Winans Way	21229-1	432	USA
Funerai	11 Marital Status 12. Was Decedent Evar in U			14. Race - American Indian,
Ē	Armed Forces? 1 □ Navar Marriad 2 □ Married 1 □ Yes 2 ☒ No			Black, Whita, etc.
þ	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specia	fy:	Specify: White
8	15. Decedent's Education	16a. Decedent's Usual Occupation		6b. Kind of Business/Industry
pie	(Specify only highest grade completed)	(Give kind of work done during m life. DO NOT use retired)	ost of working	
Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Seamstress		Furrier
BeC	17. Father's Name (First, Middle, Last)		ther's Name (First, Middle, M	
Ö	Frank Drocella		Rose Wei	phect
20	19a. Informant's Name/Relationship (Type, Print)	19b. Malling Address (Street end Num		
	Ann Rose McCauley/daughter 20a. Mathod of Disposition 20b. F	714 Winans Way Place of Disposition (Neme of cemetery, cremetory or other plece)	Baltimore	MD 21229-1432 20c. Location - City or Town, State
	4 □ Donation 5 □ Other (Specify) Me	tro Crematory,		altimore, MD
any Injury	21. Signature of Funeral Service Licenses	22. Name and Address of Fac		anviland Too
2 9	Dawn Fund O . I I A I I al	200 Frederi	ociety of M	aryland, Inc.
	Dawn F. McDonald 23a. Part 1. Enter tha disease, or complications that causad tha daat shock, or heart failura. List only one cause on each line.	h. Do not anter tha mode of dying, such	as cardiac or raspiratory arre	est, Approximata tnterval Between
ian	snock, or heart failura. List only one cause on each line.		, ,	Onset and Death
ai	Immediata Causa (Final	- 6 /20-	+ failen	//
ner	disease or condition resulting in death)	yes wer very		77
e e	Due to (c	or as a consequence of):	- 10	5/
nin	b	were worth	2 your	som you
Examine	Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Disease or Injury that initiated avents	or as a consequence of):		
	cause, Enter Undarlying Cause (Disease or Injury	nelm Vormla	I world	i cury 19
dical	that initiated avents resulting in death) Last Due to (or	r as a consequence of):	4 11'	
ž	d.,	Attono & llew	in dise	ene / by
an				6 /
Physician/	Part II. Other algntftcant conditions contributing to death but not res	ulting In the underlying cause given In Pa	art t. 23b. Did to	bacco use contribute to the cause of de
Phy			1 🗆 Y	os 2000 3 Probably 4 Unkr
by				
8			24a. Was a	ned? available prior to
olet et				completion of causa of death?
Completed by			1 🗆 Ya	s 2 No 1 Yes 2 No
	OF West and address of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the stat			/ \
Be	25. Was case referred to medical examiner? Hospital:	Other: V	ace of Death (Check only on	
2	1 Inpatient 2	EH/Outpatient 3 DOA 40		nce 6 Other (Specify)
	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year)	28b. Time of lnjury at Work?		ow Injury occurred
Certification:	2 Accident Investigation	M 1 ☐ Yes 2		
T T	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, factory, office	28f. Location (St City or Town	reet end Number or Rural Route Number, o, Stete)
Medical Certification:				-1.00
180	29a. Certifier Certifying Physictan: To the best of my known			
edlcai	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	tion and/or investigation, in my opinion, o	seath occurred at the time, d	ate and place, and due to the cause(s)
×	29b. Signature and title of certifier	29c. Licansa numbe	er 2	9d. Date signed (Month, Day, Year)
	¥ \ / / / / / / /	6-24 D24	9769	7/9/98
	- John J	James 1)	. 101	/////
	30. Name and address of person who completed cause of deatly (Iter	n 23a) (Type, Print)	211. 61	and the and

State Registrar



		Decedent's Name (First, Middle, L.	anti		Certific	cate of	Death	To Day 1=	Reg. No.		
Physic /Medi		MYRTLE	B	3.		MCC	ARTHY		L TH	1998	3. Time of Death
Exami	ner	4e. Facility Name (If not institution, gi Good Samaritat		1			4b. City, Town, or t Baltimo		th 4c. Count	y of Deeth N/A	
Funeral Director		Social Security Number 6.	Sex 7. Age	(In yrs. last		Under 1 Yeer oths Days	If Under 24 Hrs. Hours Min.		rth ay, Year) , 1928		ece (State or Foreign by) IETSEY
72 Hours aller death with the maryland natural, or Nems 23a or 28a-1 show dicel Examine, must be notified at		10e. State 10b. County		10c. City, To	own or Location	1				10	d. Inside City Limits
De-f	ctor	MD N/A		Bal	timore	5					1₽ Yes 2□ No
De C	Funeral Director	10e. Street and Number	Δ.		10	f. Zip Code	1010		10g. Citizen of		ry?
TR 23	erai	1321 Windemere	12. Was Decedent E	ver in U.S.	13. Wes [1218 Hispenic Origin? (Sp	pecify Yes or Ne	US 0- 14. Ra	A ce - America	n Indien.
lone. Than "natural", or Hems 23a or 28a-f show The Medical Examine: must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		If Yes,	specify Cub	an, Mexican, Puerto	Rican, etc.)		ck, White, e	tc.
netur	eted	15. Decedent's E (Specify only highest gr	ducetion ade completed)	16	Sa. Decedent's (Give kind o	of work done	duning most of work	king	16b. Kind of E	Business/Indi	ustry
Hygiene. ther than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Nurse	OT use retire	d)	7/	Emor	canat	Dept.
E E	Be Co	17. Fether's Neme (First, Middle, Las	1)		HULDE		18. Mother's Nam	ne (First, Middle			Dept.
	ToB	Edward Be	eesley				1	Lorrai	ne Coo	k	
5	ľ	19a. Informant's Name/Relationship	(Type, Pnint)				and Number or Ru				,
item 27 other tr		Joanne McCartl 20a. Method of Disposition	ny/daught	er 20b. Place	1321 T	Vinde	mere Ave	Bal Bal	timore	, MD	21218
_ + 0		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		Cerne	tery, crematory	or other pia	Inc. 7/7		Balti		
Department of Important: If I any Injury or Once.		21. Signature of Fune al Service Liqu	**	ma /			n Societ			,	
any is		Dawn F.Mc	Strain W	onalo	299	natio Fred	n Societ erick Ro	ty or 1. Bal	Maryla	nd, I	nc. 21228
		23e. Part1. Enter the diseese, or con shock, or heart failure. List only	nplications thet caused one cause on each lin	the death. D							Approximate Interval Between
/sician ledical		Immediate Cause (Finel	Mari	How	61111	c L	-YMPHO	A. A			Onset and Death
aminer		disease or condition resulting In death)			a consequence		7 1414 110	MA			JENK
4	iner	_		20 10 10. 00	a 001100Q001101	J 017.				1	
franc	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	D	Due to (or es	a consequence	of):					
and a	dical E	ceuse. Enter Underlying Cause (Diseese or Injury that initiated events	C			-0		_			
P. C.	l w	resulting in death) Last	·	ue to (or as	e consequence	or):					
attending for use at	Physician/M		d								
by the a	ysic	Part II. Other significant conditions	contributing to death bu	t not resulting	In the underly	ring cause gi	ven in Part i.	23b. Did	tobacco use co	ontribute to	the causa of death
88	by Ph							1 🗆	Yes 2 No	3 Prob	ably 4 Unknow
s been sign 2 should be	Completed b								s an autopsy ormed?	evei	re autopsy findings ileble prior to apletion of ceuse eath?
ate has page 2	Com							10	Yes 2 No	10	Yes 2 No
certificate rector, pag	Be	25. Wes case referred to medical exeminer?	Manitali			(/	26. Piece of Dea	th (Check only	one)		
this aid	: To	1 ☐ Yes 2 ☑ No 27. Menner of Death	Hospital: 1 Inpatier 28a. Date of trium		Outpatient 3[o. Time of	DOA Oti			idence 8 Ot)
After a funer	ation	1 Maturel 5 Pending 2 Accident Investigation	(Month, Day	Year)	Injury	28c. Inju Wo 1 [rk? Yes 2 No	200. 0 0301100	now injury occu	1100	
s after death.	Certification:	3 Suicide 6 Could not to determine of	28e. Place of Inju building, etc.	ry - At home, (Specify)	ferm, street, fa	actory, office			(Street and Num wn, State)	ber or Rural	Route Number,
Funera Funera tely fills	edical (29a. Certifier 1 ☐ Certifying Pl (Check only one)	hyeician: To the best of miner: On the basis of and manner stat	examination	ge, death occu and/or investig	rred at the ti	me, dete and place, opinion, death occur	and due to the red et the time,	cause(s) and m	anner as sta and due to	ited. the cause(s)
within 2 To the comple	Ň	29b, Stonaline and title of certifier				29c. Licens	se number		29d. Date sign	ed (Month, D	Pay, Year)
		I wan	MEDICAL	Doc	TOR	Do	05 22	77	JULY	6TH	1998
5		30. Name and address of person who					A American		A A Austra		
Sta	te.	31. Date filed (Month, Day, Year)	ATTIOGSE 32. Registre		NWA.C	KI M	TIOT HILL	LOFN	THILY LAH	1 00	N.C.
Registr		.1111 1 0 199			-Randell	2_					



Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY DISEASE CHRONIE OBSTRUCTIVE

Probably 4 Unknown 1 ☐ Yes 2 ☐ No

24e. Wes an eutopsy

24b. Were autopsy findings eveilable prior to completion of ceuse of deeth?

1 ☐ Yes 2 No

25. Wes cese raferred to medicel exeminer? 26. Piace of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA

1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 5 Pending investigation

28c. Injury et Work?

1 Tyes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as steted.

2 Medical Examinar: On the besis of examinetion end/or invastigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier

31. Deta filed (Month, Dey, Year)

29c. Licensa number D 26 395

Julke 30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print)

MD 5. JUYCA SURJIT

Julia Davidson

State Registrar

DHMH 16 Ray 6/95

Box 68760 P.0.

Baltimore, Maryland 21215-0020

LAURA

The law requires that the death certificate be executed

Division of Vital Records, Hospital or Attending Physician: hours after death. uneral Director: A ily filled in by the fi

Completed

Be

Certification: To

Affer

death.

To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

1 Neturet

2 Accident 3 Sutcide 4 Homicide

6 Coutd not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

32. Registrar's Signature

28d. Describe how injury occurred

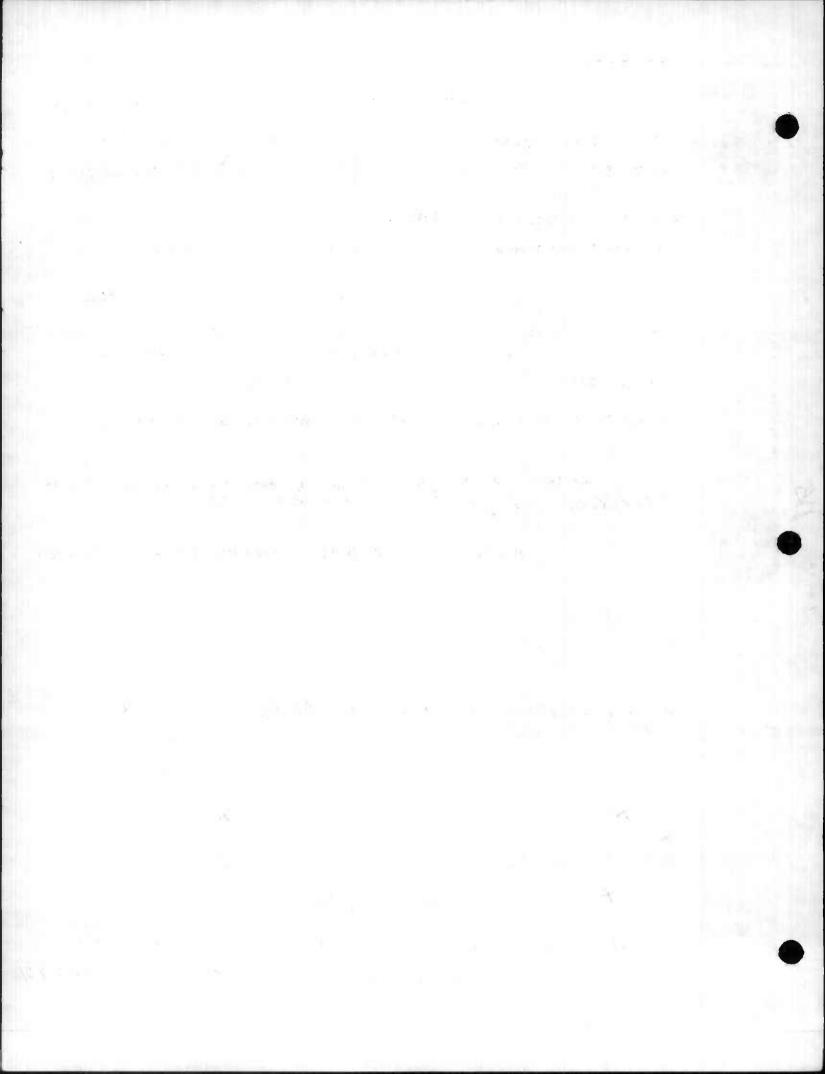
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yas 2 ☐ No

29d. Date signed (Month, Dey, Year)

6-23-98

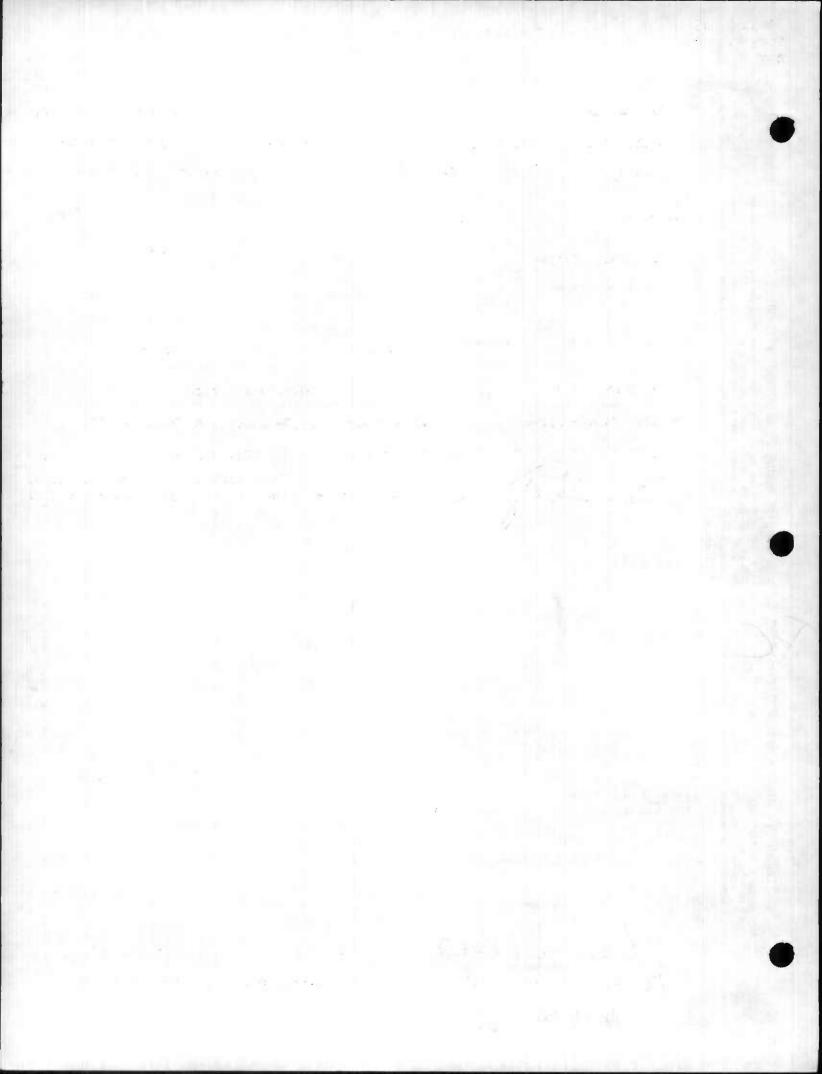
821 N. EUTAW ST. BALTIMORE MD21201



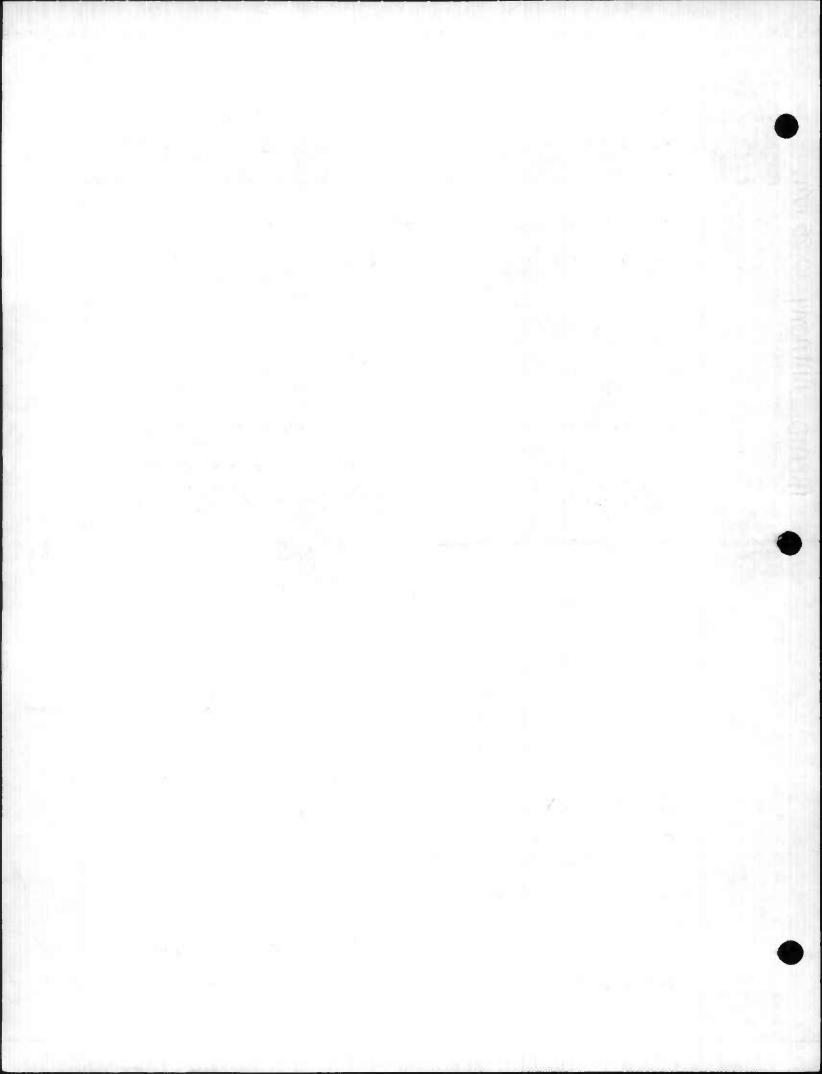
98-3872-005 TONY K. MANN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

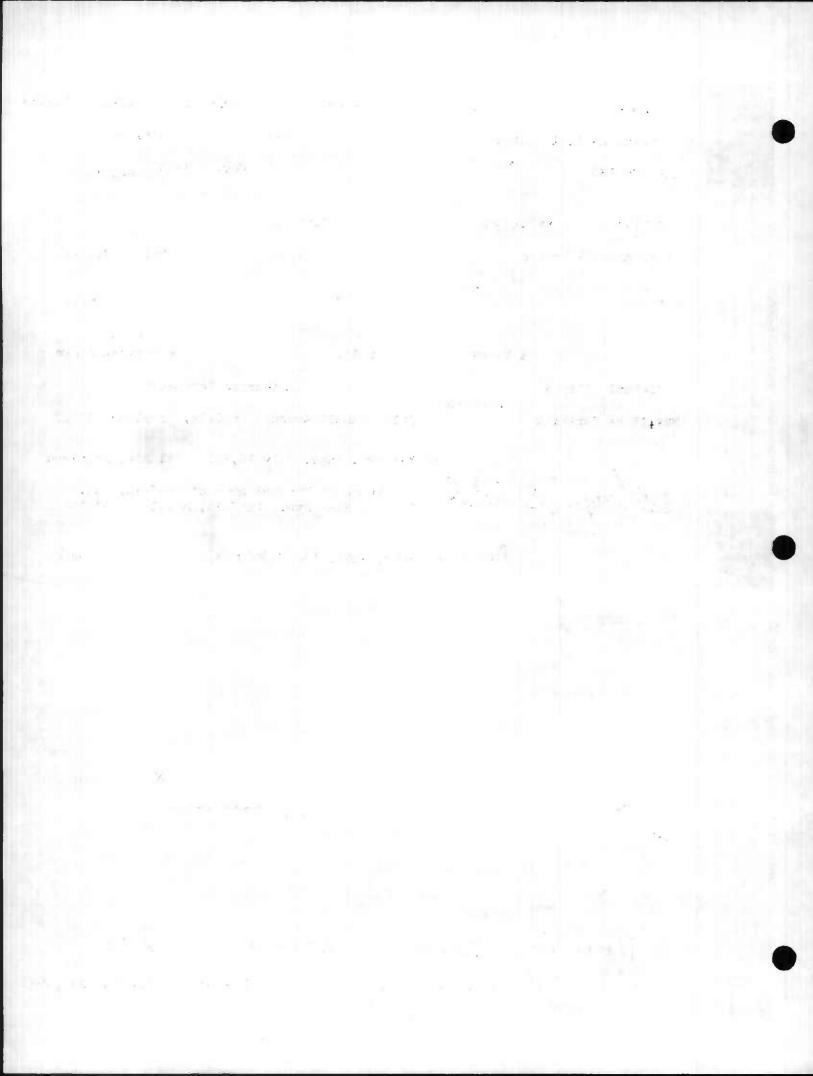
#23 F	ART I, 27, PER MEO F			Department of Certificate of		ental Hygie		8 21	244	
siclan edical	Decedent's Name (First, Middle, Tony K. Mann As Facility Name (If not Institution,	Last)			4b. City, Town, or Lo	JULY 07.	Dey 1998 4c. County	Year (Time of Deeth	
niner al or	ST. JOSEPH'S HO 5. Social Sacurity Number 215-82-6561	SPITAL E.R.	ga (In yrs. last bi 33	rthday) If Under 1 Yaa Months Dey	TOWSON If Undar 24 Hrs.	8. Data of Birth (Worth, Day, Ye	BALTI	MORE CO	(State or Foreign	
	Usual Rasidence of Decedent 10e. Stete 10b. County		10c. City, Tov	n or Location				10d. I	Inside City Limits	
tor	Maryland		Baltimo	re				1	Yes 2 No	
Director	10e. Street end Number			10f. Zip Code		10g.	Citizen of V	What Country?		
	2715 Hanson Ave	nue		21209			U.S.A.			
	11. Marital Status 1 Naver Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forcas 1 Yes 2 ff Yes, Give Year or Dates;		13. Was Decedant of If Yes, specify Cu	Hispanic Origin? (Spe ban, Mexican, Puarto I o <i>Specify:</i>	cify Yes or No- Rican, atc.)	No- 14. Rece - Amarican Indian, Bleck, Whita, etc. Specify: Black		ndian,	
	15. Decedant's (Specify only highest Elemantary/Secondary (0-12)			Decedant's Usuel Occ (Give kind of work don life. DO NOT usa retii Painter	e during most of working	19	16b. Kind of Business/Industry Housing			
	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	other's Name (First, Middla, Maiden Surname)				
	Leroy Thomas Man	n			Dorothy K	etterer				
	19a. Informant's Name/Relationsh		19	b. Mailing Address (Stre			ity or Town,	Stata, Zip Coo	(e)	
-	Dorothy Mann - M 20a. Mathod of Disposition 1	3 □Removal from State	20b. Plece o	15 Hanson A of Disposition (Name of cry, cramatory or other p on Cemetery	(ace)		c. Location -	City or Town,		
	21. Signature of Funeral Service L	cension	_	22. Nama and Add	ress of Fecility Der Heights Av	rick C e.,Baltin	Jones more,	Funera Maryla	1 Home,	
Examiner	Immediata Cause (Final disaese or condition resulting in death)	a	ASTHMA Due to (or as a	consequence of):						
	Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last	c		consequence of):						
	Part II. Other significant condition	s contributing to death b	out not resulting	In the underlying ceusa (given in Part f.	23b. Did tobacco use contribute to the cause of c			causa of death	
					24a. Was an a	utopsy	24b. Wera e	autopsy findings ola prior to		
						Yes	2 No	comple of daet		
pe Completed	25. Was cese referred to medical examinar?				26. Place of Death	(Check only one)		1		
2	1₩ Yes 2□ No	Hospital: 1 ☐ Inpati	-	utpatient 3 DOA		ne 5 🗆 Residend				
Certification.	27. Manner of Deeth 1 Natural 2 Accident 3 Sulcide 4 Homicide	ot be 28e. Place of fn	y Year)	Time of fnjury M 28c. In W 11 arm, streat, factory, office	☐ Yes 2 ☐ No	28d. Describe how 28f. Location (Stree City or Town, S	et and Numb		oute Number,	
edicai cer	29a. Certifier 1 ☐ Certifying	Physician: To the best	of my knowledg	a, death occurred at the nd/or invastigation, in my	tima, date end place, a	and dua to tha caus	sa(s) and ma	anner as stated and due to the	d. ceuse(s)	
Me	29b. Signature and title of certifier	tober	w	0.0	nse number			d (Month, Day,	Year)	
ate	30. Name and address of parson w 31. Date filed (Month, Day, Year)	the complated cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of completed cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause o)	111 Penn S	street, Bal	timore, 1	Maryla	and 212	01	
rar	JUL 1 019	198 July	a Davidser	Mandale						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ANTHONY S. MENTO JULY 8 1998 10:25am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MANOR CARE NURSING BALTIMORE ROSEDAL F 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Birthplaca (State or Foreign Country) Months Deys 1€M 2□F Hours 217228044 **Director** 83 JUNE 15,1915 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits trsumetic svent, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 8327 PHILADELPHIA ROAD Funeral 21237 USA 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 8 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 th end Mental Hygiene. 7 is marked other than "m Elementary/Secondary (0-12) College (1-4or 5+) BARBER SHOP 6 0 BARBER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be JOSEPH MENTO 10 **AGATHA** 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health e Important: If Itam 27 Is any Injury or other tre JOSEPH S. MENTO / SON 1227 DALTON AVENUE ROSEDALE, MD 21237 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State 4 Donetion 5 Other (Specify) GARDENS OF FAITH 7/11/98 BALTIMORE, MD 21. Signeture of Funeral Service License 22. Name end Address of Fecility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physiclan** /Medicai Immediate Cause (Final disease or condition resulting in death) Examiner Examiner -transit Hospital or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or es a consequence of) physician s the buriel Box 68760. Physician/Medical Due to (or as a consequenca of): Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco usa contributa to the causa of death? signed by t 10 Yes 2 No 3 Probably 4 Unknown þ chronic Rever insufficiency 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24e. Was an autopsy peeu has certificate t ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Netural 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide hours after in 24 hour. the Funeral Dire 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29e. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (fem 23a) (Type, Print) 7600 Osler Drive suite 203 I M.D Koul TOWSON, UD 21304 32. Registrar's Signature 31. Date filed (Month, Dey, Yeer) State JUL 1 0 1998 Registrar

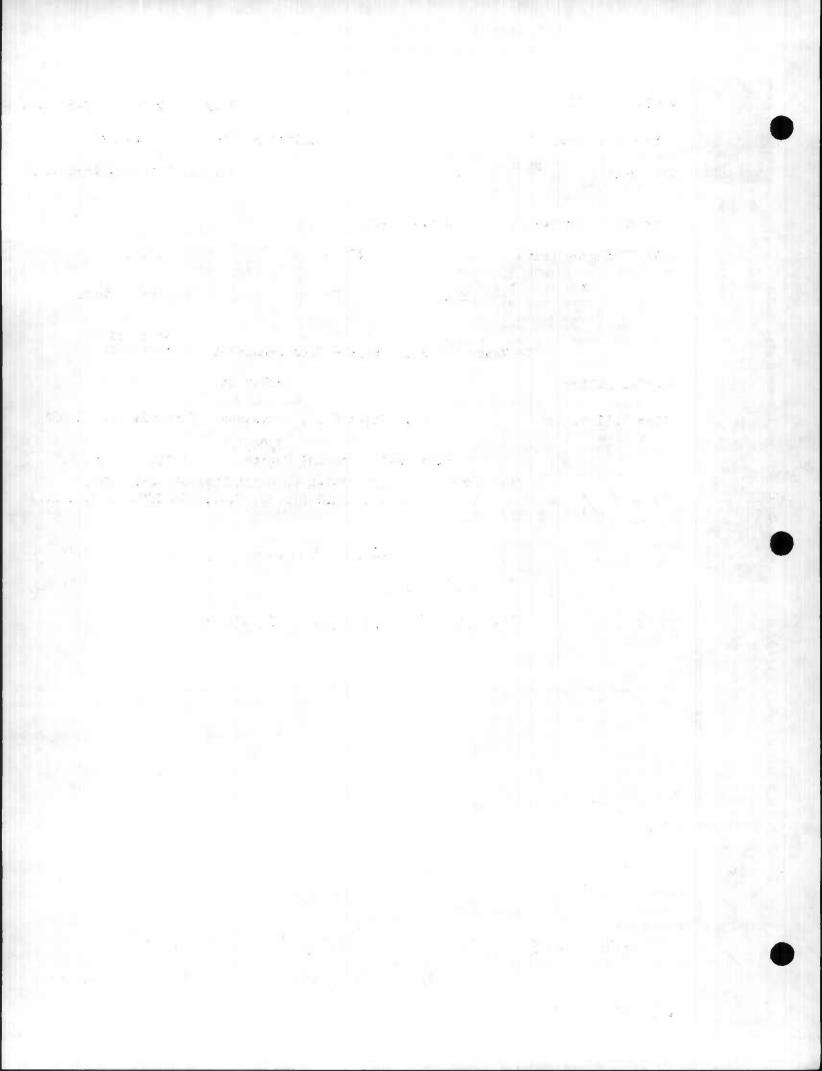


sician	I, Liter	cedent's Neme (First, Middle,	, Last)				Death	2. Dete of Dec	reg. No.		3. Time of Death
edical		Barbara		E.		McLea		July	08 ^{Day}	1 ⁹ 98	2:50AM
miner	4e Fa	cility Neme (If not institution, Multi Medica		n <i>ber)</i>		4	lb. City, Town, or L TOWSON	ocation of Death	4c. County Balti		
ral tor			6. Sex 1 □ M 2 → ¥	7. Age (In yrs. 84	lest birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth	1 '9'1 '3	9. Birthpla Country Maryl	ce (Stete or Foreign y) and
-10	Usuel 10a. S	Residence of Decedent State 10b. County		10c. Cit	y, Town or Lo	cation				100	1. Inside City Limits
tor	M	aryland	Baltimor	e		D	undalk				1 ☐ Yes 2 No
Director	10e. S	Street and Number	DOLE GENERAL			10f. Zlp Code			10g. Citizen of V	Whet Country	y?
rail	1	812 Maxwell A					21222			ed Sta	
by Funeral	3 [arital Stetus □ Navar Marriad 2 □ Marrle ಔ Widowed 4 □ Divorced		re		Ves Decedent of H f Yes, specify Cube □ Yes 2 1 No	ispanic Origin? (Sj en, Mexican, Puerto Specity:	pecify Yas or No- b Rican, etc.) 14. Race · American Indian, Black, White, etc. Specify: White			
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	17. Fe	other's Neme (First, Middle, L	1 Yea	ır		Sales	18. Mother's Nem	ne (First, Middle,	Depart	_	store
000		Michael Filip					Katha	rina Ros	enauer		
		Informent's Name/Reletionsh		ughter		ng Address (Street 2 Maxwell					Code) 21222
	1	Method of Disposition ☐ Buriel 2 ☐ Cremetion ☐ Donelion _ 5 ☐ Other (Spe		State	cemetery, cren	sition (Neme of natory or other pleamann) Mem. Gdn		Dete 10,1998	20c. Location - Bel Ai		
an/Medical Examiner	Sequification of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	Part1. Enter the displace, or o shock or heart faultre. List of side the condition should be condition and the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the condition		Due to (c		g enous uence of):					Approximate interval Batween Drisat and Death
5	Pert II	. Other significant condition	ns contributing to de	eath but not res	ulting In the u	nderlylng cause giv	en in Pert I.	23b. Did	obacco uae co	ntribute to 1	the cause of death
								10	Yes 2 No	3 Probe	ably 4 ☐ Unknow
										24h Wer	a autonou tindinaa
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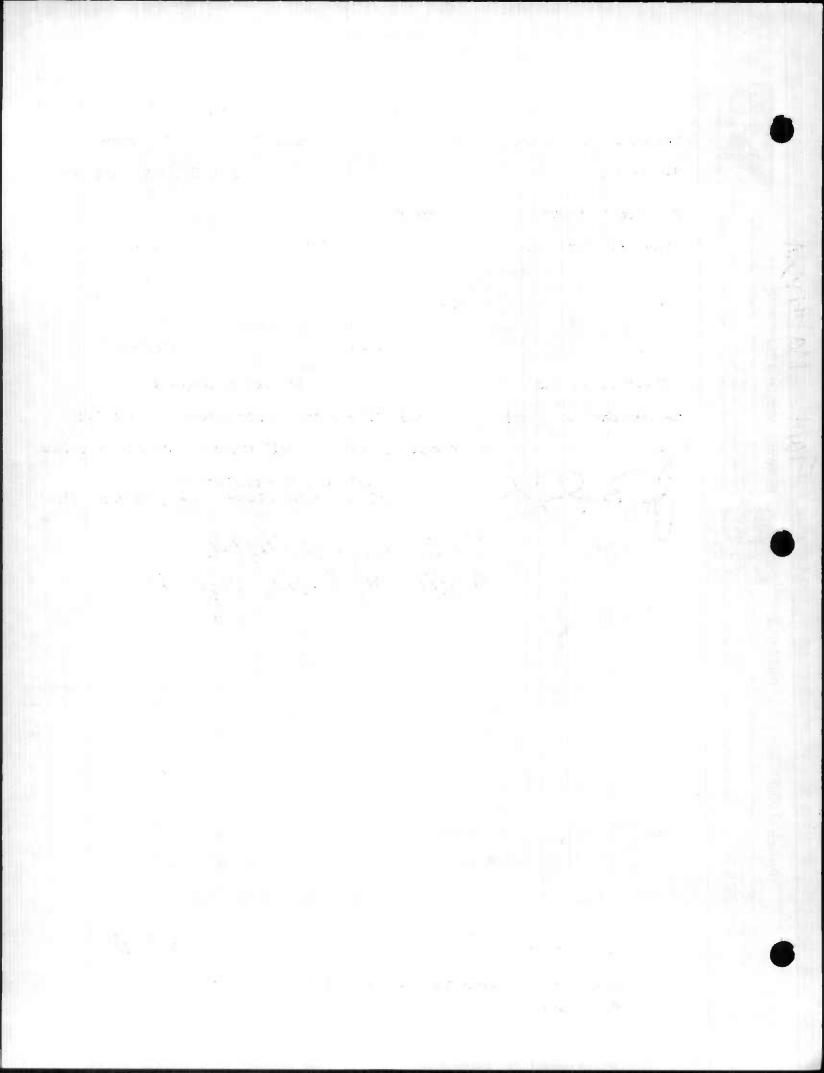
State of Maryland / Department of Health and Mental Hygiene Q Q 1

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-	-	23a. Part1. Enter the disease, or shock, or heart failure. List	calculations that cause	ed the death.	232 Do not enter	the mode of dvi	L STREET	lac or respirator	WASI errest.	HINGTO	-	C. 20012
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o.	thet the danged by the sedetached very Physical	Part It. Other significant condition	ons contributing to death	but not result	ting in the und	lerlying cause gi	ven in Part I.				_	cause of death?
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	rs after el Direction by	building, etc. (Specify) City or Town, State)										
	he Hospital in 24 hours in the Funeral plately filled edical Ce	29a. Certifier 1 ☐ Cartifyir (Check only 2 ☐ Medical	ng Physician: To the best Examiner: On the basis									
	within 24 hours after the Funerel Dir completely filled in Medical Cert		and manner s	tated.		29c. Licens		75 77 75		ate,signed (
	D T T T T T	29b. Signature and title of certifie	2	140		11/n			290. 0	2 C	Total, Day	, 1001)
	Λ	- Caller -	1	M		170	110		1	1010	T.	
	100	30. Name and address of person	who completed cause of	death (Item :	23a) (Type, Pr	rint)	, W.	#30	7	422	0 -	20962
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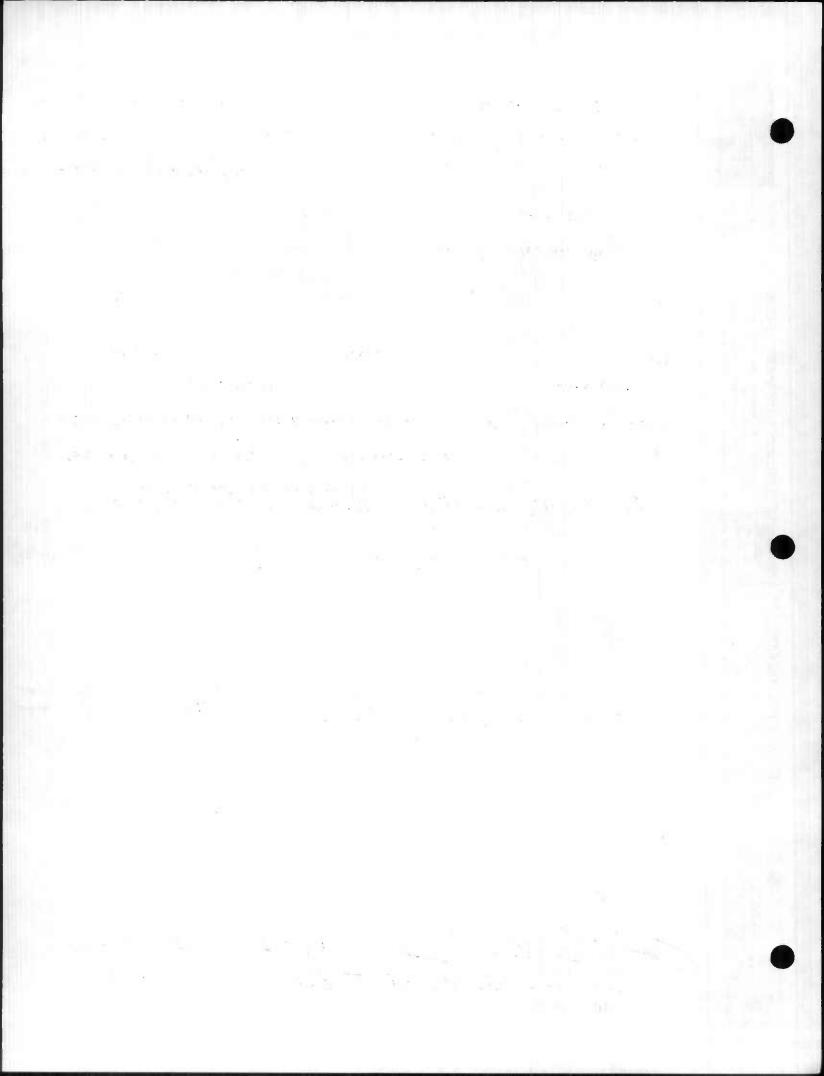
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	e. Street and Number 1706 Reynolds Roa	ad		10f. Zip Code 21	021		10g. Citizen of V USA			
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99 0	Frank J. Matthew	1			Barbar	a M. Geo	pfert			
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30.	The second of persons will be		Eastern		Essex, Mai					



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3 Day **Physician** J Month 8:55pm 1998 NAOMI MURPHY Ν. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Baltimore 1304 Gunpowder Crossing lane Fssex If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Min. May 16, 1921 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 1 □ M 2√ F West Virginia 220-24-6096 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Important: If Item 27 is marked other than "natural", or Hems 23a or 28a-1 show any Injury or other treumatic event, the Webical Exponent must be notified at once. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Baltimore Essex 1 ☐ Yas Ž ☐ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 1304 Gunpowder Crossing Lane Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Dates: 1 ☐ Nevar Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 18. Mother's Name (First, Middla, Malden Surname) 17. Fathar's Nama (First, Middla, Last) Norval Paune Glenna Upton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Ralationship (Type, Print) Edgewood Md. 21040 1309 G Clover Valley Way Richard L. Murphy / son 20b. Pleca of Disposition (Nama of cematery, cramatory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 7/7/98 Baltimore Md. Holly Hill Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly FuneralHome of Essex 300 Mace Ave. Baltimore Md. 21221
Do not entar the mode of dying, such as cardiac or raspiratory arrest, Part1. Entar the disease, or comp shock, or heart failure. List only Approximata Intarval Batween Onsat and Death ications that caused the death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Coat cell 13 months cancer lung Examiner Due to (or as a consequence of) Physiclan/Medical Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Division of Vital Records, P.O. Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown obstructive pulmonary disease ۵ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has the 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminar? Be 28. Place of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No After this funeral 27. Magnar of Death 1 Natural 2 Accident 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: or Attending 5 Panding investigation 1 ☐ Yas 2 No death after death 6 Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicida 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) filled in by 4 Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar within 24 hou To the Fune compiataly fil edical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and ticle of continu 29c. License number . Neme and addrass of person who complated cause of death (Item 23a) (Type, Print) dans to south 600 N. Wolfe ST Ballmore 40 21287 32. Registrar's Slaveture State Registrar



If Under 1 Yeer

Months

Deys

Birthplace (State or Foreign Country)

10d. inside City Limits 1☐Yes 2☐No

Approximate Intervel Between Onset and Deeth

24b. Were eutopsy findings eveileble prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

4c. County of Deeth

BALTIMORE

Bleck, White, etc.

Death

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S	tate of Maryland	/ Department of Health and	Mental Hygie	ene) 8	2	1250
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DOROTHY	E. MICKE	EY	JIII.Y		998	01:4

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Hours

4b. City, Town, or Location of Death

Min.

8. Dete of Birth (Month, Dey, Year)

Physician /Medical 4a Facility Neme (If not institution, give street end number) Examiner

DOROTHY

5. Social Security Number

GREATER BALTIMORE MEDICAL CENTER

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Director

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Baltlmore, Maryland 21215-0020 permit. Pages Department of Important: If it any injury or o ō

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Physician /Medical Examiner

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Physician: or Attending in 24 hours after the Funeral Director: After Andreity filled in by the funeral production of the funeral filled in by the funeral filled in by the funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral fu within 2 To the

Division of Vital Records, P.O. Box

212-12-6239 SEPT. 19,1922 MARYLAND Usual Residence of Decedent 10a. Stete 10h County 10c. City, Town or Location BALTINORE Directo MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21206 U.S.A. 4402 BOWLEYS LANE APT 2D Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give A Yeer or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify NEGRO 3 ☐ Widowed 4 ☐ Divorcad þ Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Mary Lou Bartee PLUMMER GILLIAM 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 4110 GLADDEN AVE. BALTO, MD. 21213 ROBERT MICKEY son 20b. Place of Disposition (Name of cametery, cremetory or other placa)

July 13, Date 20c. Location - City or Town, State 20e. Method of Disposition 1 Deniel 2 Cremetion 3 Removel from State GARRISON FOREST VETERAN CEM. 4 ☐ Donetion 5 ☐ Other (Specify) OWINGS MILLS, MD. 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 21. Signature of Funeral Service Licenses 1412 E. PRESTON ST. BALTO, MA. 1412 E. PRESTON ST. BALTO, I 23e. Pent1. Enter the disease, of complications that church shock, or heer failure. List only one cause on each ACUTE MAYO CARDIAL INFARCTION

RESPIRATORY FAILURE

Due to (or es e consequence of):

MULTIPLE MYLOMA Immediate Cause (Final disease or condition resulting in death) Examine Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury Ihet Initiated events resulting in deeth) Lest Physician/Medical Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? MALIGNANT PLEURAL EFFUSION 1 Yea 2 No 3 Probably 4 Unknown þ ANEMIA Completed 24e. Wes en eutopsy performed? 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Neturel 2 Accident 5 Pending 1 Tyes 2 No investigation 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the cause(s) end manner as stated.

I Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier edical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier A ! Wegenny Name and eddress of person who completed cause of death (Hem 23e) (Type, Print)

AYMUMN A WZEMD A 780

Dete filed (Month, Day, Year)

32. Registrar's Signature YORK RD #300, TOWSON 21204

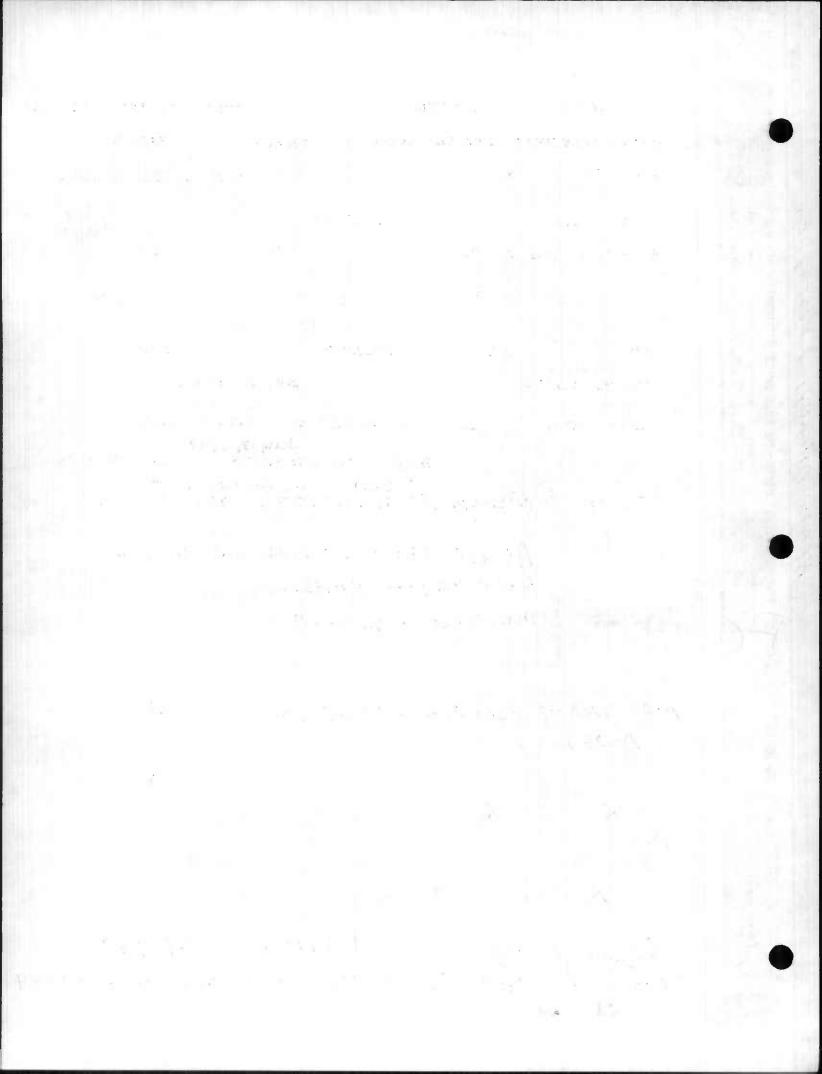
7. Age (In yrs. lest birthday)

75

Yrs.

Registrar

State



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듬	10e. Street and Number		10f, Zip	Code			10	0g. Citizen of	What Coun	try?
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2	MARTIN EMMERT COPENHAVER				A	NNA	BUTTS			
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E	determined 289. Piece of In	jury - At home, fe tc. (Specify)	rm, street, fectory	, offica		1	28f. Location (Str. City or Town,		ber or Rurai	Route Number,
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Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of Medical Examiner: On the basis of end menner s	it examinetion en	, deeth occurred ed d/or investigation,	In my	me, date end opinion, deeti	d plece, e h occurre	end due to the ce ed at the time, da	use(s) end m ite and place,	enner as sta end due to	ated. the ceuse(s)
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to	31. Date filed (Month, Day, Year) 32. Regist	rer's Signeture	rieulla		men	5	(C. 14	4-	LIG.	
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State Registrar

Physic /Medi Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mantal Hygiena. Important: if item 27 is marked other than "naturel", or items 23a or 28a-4 show any injury or other traumatic event, the Mad on Examiner must be notified and once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death cartificate be associted within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Orourke

Leona P.

Baltimore, Maryland 21215-0020

State of Maryland / Department of Health and Mental Hygiene 21252 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** June 26, 1998 Jeanne Marie Patrick 11:55 p.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Laurel Regional Hospital Laure1 Prince George If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York If Under 1 Year 8. Date of Birth (Month, Day, Year) Oct. 24,1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 65 Yrs Director 074-24-1489 Usual Residence of Deceden the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ns 23s or 23s-f shormast be notified at 1 ☐ Yes X□ No Director Howard Jessup 10a. Street and Number 10f Zin Code 10g. Citizen of What Country? 8305 Ari Court #2-B 20794 IISA Berns 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. filed within 72 hours after Hygiene. Ther then "neturel", or its 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Marriot Corporation 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 is marked off Be Louis Foote, Sr. Mazie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Important: If Item 27 any injury or other to Ramona Patrick/Daughter 8305 Ari Court #2-B, Jessup, Maryland 20794 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Washington Cr. 6/30 Laurel, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a Thrombo-Embolism Examiner Due to (or as a consequence of) Examiner Poor Left Ventricular Function in and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Cardiomyopathy Box 68760. Physician/Medical Due to (or as a consequence of): Hypetension Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. XXYee 2 No 3 Probably 4 Unknown signed t Diabetes Mellitus þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Cerebrovascular Accidents page 2 s 1 ☐ Yes 1 ☐ Yes 2 No Peripheral Vascular Disease 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ₩ inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation Attending death. 1 Yes 2 No within 24 hours after death.

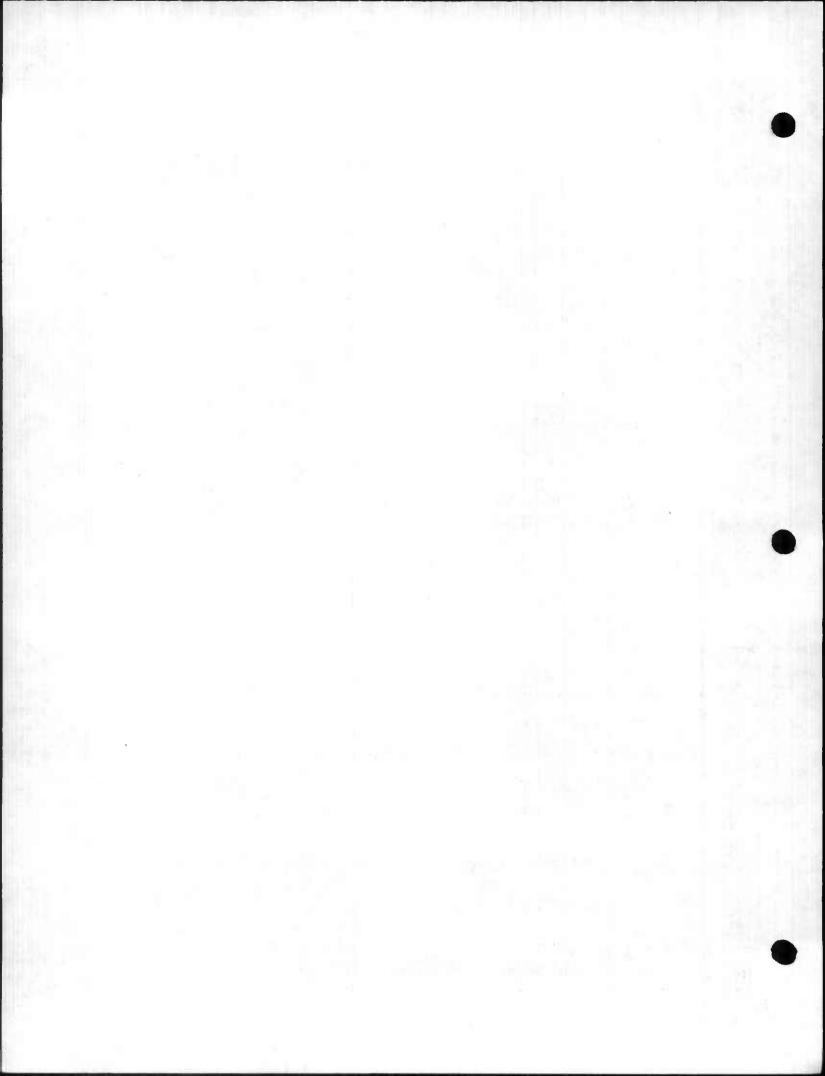
To the Funeral Director: A completely filled in by the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 5 TCCortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) the th 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 721294 MND 30. Name and eddress of person who completed cause of death (item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

Julia Davidson-Randelle

10820 HICKORY RIDGE ROAD COLUMBIA, M.D 21044



State of Maryland / Department of Health and Mental Hygiene 21253 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 3. Time of Death Edythe Boatner Pearman 10, 1998 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Stella Maris Hospice @ Mercy Baltimore N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Days Hours Min. | APR 5, 1925 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 1 ☐ M 2 🖫 F Illinois 321-24-3586 73 Yes 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Randallstown 1 Yes & No 10f. Zlp Code 10g. Citizen of What Country? 3452 Carriage Hill Circle 21133 USA 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Specify African 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade complated) 16e. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Collega (1-4or 5+) Elementary/Secondary (0-12) Teacher Public School System 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surnama) Robert Boatner Emma Duff 19a. Informant'a Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Allenby W. Pearman/husband 3452 Carriage Hill Rd. Randallstown, MD 21133 20b. Placa of Disposition (Name of cemetery, crematory or other placa) Date 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ACremetion 3 ☐ Removal from State Metro Crematory, Inc. 7/10/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Jun C Cremation Society of Maryland, Inc. Cremation Society of Maryland, Inc.

299 Frederick Rd. Baltimore, MD 21228

Approximate shock, or heart failure. List only one cause on each line. 1 year Esophaseal Cancer Due to (or as a consequence of): Due to (or as e consequenca of): Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of daath? 24s. Was an autopsy performed? 1 Tyes 25 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) STELLA MARIS AT MERCY Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding investigation

1 ☐ Yes 2 ☐ No

D40480

Belai-

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) end manner stated.

29c. License number

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Important if its any injury or oth once.

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 23a-f show traumatic event, the Medical Exerciner must be notified at

72 hours after

ould be filed within Mental Hygiene.

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Die in

PEARMAN, EDYTHE

Maryland 21215-0020

Baltimore,

5. Social Security Number

10e. Street end Number

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to Immediate cause. Entar Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest

1 Yas 2 No

27. Manner of Death

2 Accident

3 ☐ Sulcide

29a. Cartifier (Check only

4 \(\text{Homicide} \)

11. Marital Status

10a. State

MD

Funeral Director

þ

Completed

Be

Lo

Usual Residence of Decedant

Physician/Medical Examiner Brid signed by the e ρÁ Completed Be Certification: To

Division of Vital Records, P.O. Box 68760 The law requires that the death certif funerei filled in by the

Nospital or Attending Physician: The law 24 hours effer death.

Funeral Director: After this certificate hes i To the To the F

31. Date filed (Month, Day, Year) State Registrar

edical

30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print) >6 >2 FERNANDO

JUL 1 0 1998

29b. Signeture end title of certifier

6 Could not be determined

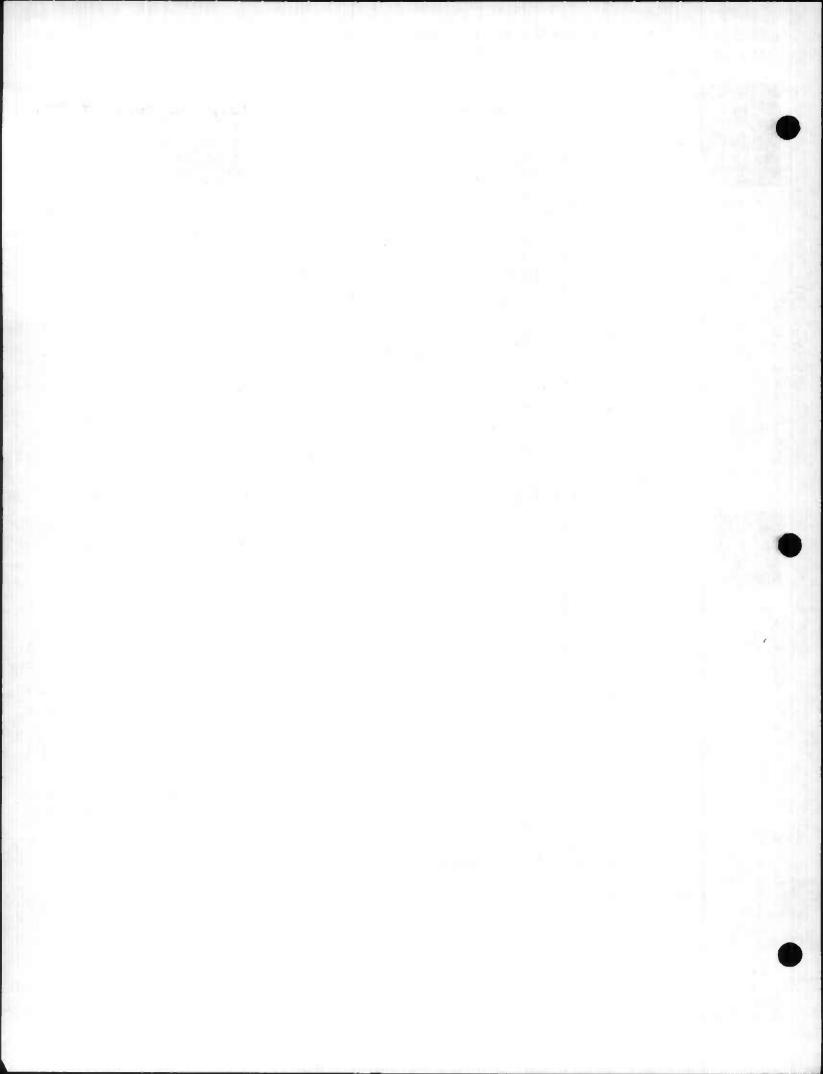
FERRO, MD 32. Registrar's Signatura

Zamon

Filia Davidson Randelle

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

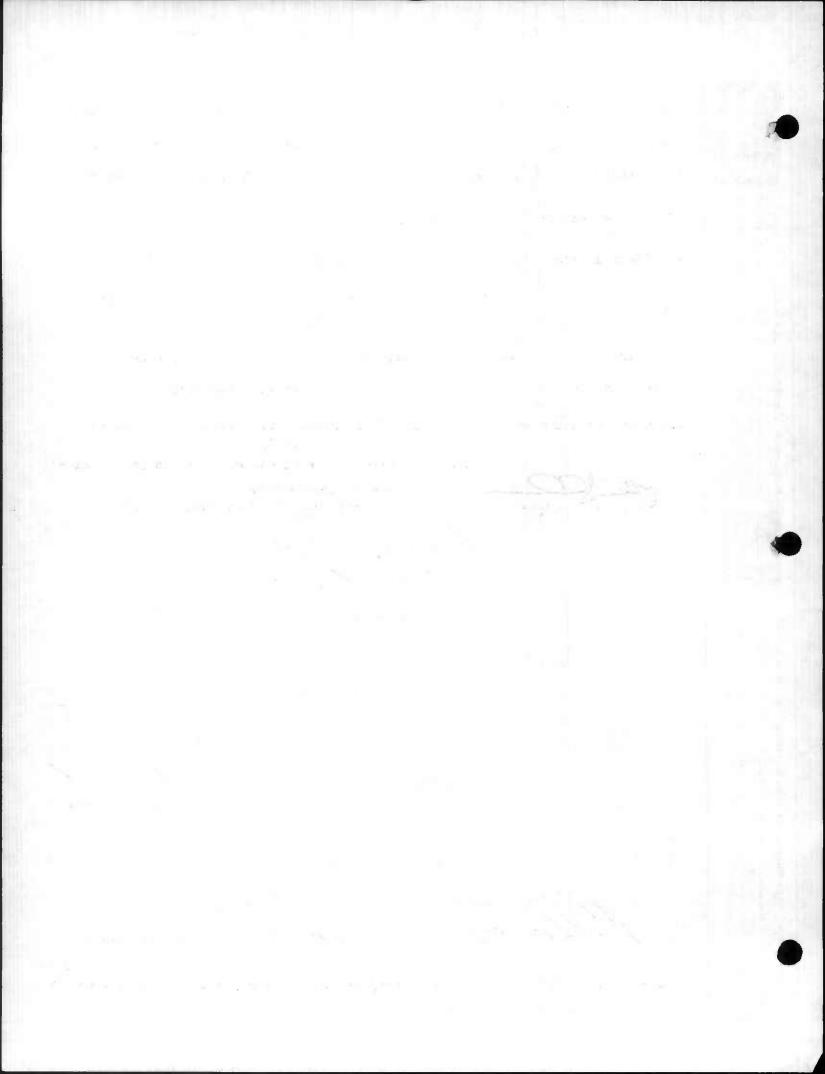
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

21251

							Cen	tificate c	of E	Death			Reg. N	o.		las 1	404
		1. Decedent's Name	e (First, Middle, L	est)								2. Date of De				3. Time o	of Death
Physician	_	Teresa	Mari	e	Powe.	11						Month July	8	ay	Year 1998	1:15	рм
/Medicai Examiner		te. Fecility Name (/				alta alta			46	c. City, Town	n, or Lo	cation of Deat		c. County		1.10	FFI
Examiner	ľ		laris Hos						١.	m •			1 /2				
	٠,	5. Social Security N		Sex	7 Ann	(In yrs. last birth	day	If Under 1 Ye	ear	Timon: If Under 24	Lum	8. Date of Bi	rth	Ba_	ltimo	re_	or Foreign
Funeral Director	II.			1□ M 2[T.F.	V		Months Da			Min.	(Month, Di	ay, Yea		Cour	lace (State itry)	or roreign
Director	Ъ	100-01-6 Usual Residence of		2	8	4						Oct. 1	6 1	913	It	aly	
ž	- 1-	10a. State	10b. County			10c. City, Town	or Loc	ation							1	Od. Inside (City Limits
sid at		MD	Baltimo	ro		Timoni											s 2 No
notified at rector	-			1.6		TIMORIT	uiii	Lat Hills									X
be notified be notified Director		10e. Street and Nur	nber					10f. Zip Cod	10				10g. C	itizen of \	What Cour	itry?	
rai rai		21 Silve	r Stirru	p Ct.				21	09:	3				USA	A		
r Items 23s niner must Funeral		11. Maritai Status		12. Was	s Decedent E ed Forces?	ever in U,S.	13. W	as Decedent of Yes, specify C	of His	spanic Origin n, Mexican, I	n? (Sp∈ Puerto	ecify Yes or No Rican, etc.)	0-		a - Americ ck, White,		
		1 Never Marri	ed 2 Married	10	Yes 2 N	0		□Yes 2□1		Specify:		, ,					
En la		3 ☐Widowed	4 Divorced		r or Dates:			X X	140	Specify.				Specify	Wh	ite	
Completed		/Cnee	15. Decedent's E	ducation	(nt nel)	16a. D	ecede	ent's Usuai Oc ind of work do O NOT use re	cupat	tion	نام مدید ک		16b.	Kind of B	usiness/In	dustry	
Mand		Eiementery/Seco			ege (1-4or 5-	- 9	life. D	O NOT use re	tired)	uring most o	I WORK	ing					
a lo		12			ı/a		ome	maker					Over	n Hon	no		
Be C		17. Father's Name	(First, Middle, Las		.,		Ome	marcol		18. Mother's	s Name	e (First, Middle					
100		Frances	co Querc	10						٨٣٥	1 .	Dogoh	a = 1.				
To		19a. Informant's Na			w)	10b 8	Mailine	Addenna /Cte	root o			Pasch			Ctata 7ia	Codel	
traumatic																	
ğ	-	Linda Sa		ghter		2	1 S	ilver	St	irrup	Ct.	, Timo					
5	1	20a. Method of Disp 1 ₩ Buriai 2 (osition ⊒Cremation 3 [Removai	from State	20b. Pieca of Dicemetery,	crem:	atory or other	place) 7/1	11/9	8 ^{Dete}	20c.	Location -	City or To	wn, Stete	
lay and			5 Other (Speci		nom orato	Dulaney	Va	llev M	emo		1		Ti	nonii	ım M	D 210	93
는 N		21. Signature of Fu	naral Salvice the	M500			22.	Name and Ad	dress	s of Fecility				IIOIII C		210	,,
ESS		700		_			Le	emmon F	Fun	eral 1	Hom	e					
	+	23a Part1 Enter th	nael J.	flagle	e that caused	the death. Do no	10	W. Pad	don	ia_Rd	rdiac c	Timoniu	ım.	MD 2	1093	Approxima	ato.
	1	23a. Part1. Enter the shock, or hear	rt feilure. List only	one caus	e on each line	Θ. /	· · · · · · · ·		u)g	4 4	110000	or recognition y	,,,		1	Interval Be Onset and	etween
sician edicai	1	Immediate Cause (Einal			RESPINA	1/	~ ·		Silor.	2					011001 01110	Doutil
miner	-	disease or condition resulting in death)		8											- 1		
	1	resulting in death)				Due to for as a co	nsequ	enca of):	1	1	1	, us			i		
rial-transit Examiner				b		e are				<i>></i>							
s the burial-transit	1	Sequentially list cor	nditions,	U.		Due to for es a co	nsequ	ence of:	,								
		Sequentially list cor if any, leading to im cause. Enter Unde	rlying			Ostes	24	duite	3						1		
edical		Cause (Disease or that initiated events resulting in death) L		C		Due to (or as a co	nsequ	ence of):									
as t		resulting in death) L	ast			·	•								1		
for use as the				d											<u> </u>		
Cia for	-	2-11-21-11															
detached for u	, '	Part II. Other signifi	cant conditions	contributing	g to death bu	t not resulting in t	he und	derlying cause	give	n In Part i.						the cause	- Indiana
Ph												1 🗆	Yes	2□ No	3 ☐ Pro	bably 4E	Unknow
2 2															T		
should												24a. Was	en eut		av	ere autopsy ailable prior	to
50 N D	-															mpietion of death?	cause
Page												10	Yes	2 No	10	Yes 2	No
		25. Was case refer	red to medical							00 51-	4.5		_	-2-140		100 ZL	
Be		examiner?	_	Hospital:				-5	Other	p+		(Check only				Kor	ree
<u></u>		1 ☐ Yes 2 2 27. Manner of Death			1 Inpatier Date of fnjun		_	3LI DOA	-	4 LI Nurs	- 1	me 5 Reside				y) /	
funeral fon:	1	LENatural	5 Pending		(Month, Day			28c. fr				28d. Describe	now in	ury occur	red		
the cat		2 ☐ Accident 3 ☐ Suicide	Investigation 6 Could not to					M 1	1 🗆 Y	'es 2□No	2						
completely filled in by the fi		4 Homicide	determined	280.	Piace of Injubuilding, etc.	ry - At home, farm (Specify)	n, stre	et, factory, offi	ica		1	28f. Location (City or To	Street a	and Numb te)	per or Rura	/ Route Nur	m <i>ber</i> ,
led in by the funera Certification:	1																
Sa.		29a. Certifier (Check only	12 Carlifying P	hysician: 1	To the best of	my knowledge, o	death	occurred et the	e time	e, dete end p	piece, e	end due to the	cause(s) and me	enner as s	ated.	
edical		one)	2 Medical Exa		the basis of a menner stat		or inve	estigation, in m	ny opi	inion, deeth	occurr	ed at the time,	dete a	nd pieca,	end due to	the cause	(s)
Σ		29b. Signature age	of certifier	//	po)		29c. Lic	ense	number	1		29d. D			Day, Year)	
·		1	Vocal	212		7		1/	//	number	4		7	7 . 9	. 40		
2	13	30. Name and eddre															1093
			khuda, M	1.D.	Stel	la Maris	Нс	spice,	2	300 Di	ulaı	ney Val	ley.	Rd.	Timo	nium,	MD
State	1	31. Date filed (Mont	n. Day. Yeer)	900	32. Regista	s Signature	מל	md . 00									
tegistrar			AALT A K	30	du	an ministration	-No	There									
	_																



		State of Maryland	I / Departm <i>Certific</i>	nent of F	lealth a Death	nd Me		ene 9 (2	125	5
	1. Decedent's Name (First, Middle, Last)					2.	Date of Death			3. Time of	Death
n ai	mary D. RAND						Month Y	Say	Year 999	9:0	1500
er	4a. Facility Name (If not institution, give str	reet and number)			b. City, Tow	n, or Local	ion of Death	4c. County	of Death		
	CHARLESTOWN CARE		M. P. I	lada d V	CA'	TONSV	ILLE	E	BALTIM		
	5. Social Security Number 6. Sex 1	7. Age (In yrs. la: 81		Inder 1 Year oths Deys	Hours 2	Min.	(Month, Day,			ace (Stete o	r Foreign
	Usual Residence of Decedent	01				J	UNE 24	1917	MARY	LAND	
	10a. State 10b. County		Town or Location						10	d. Inside Cit	ty Limits
cto	MD BALTIMOR	E	CATONSVI	LLE						1 🗆 Yes	2∭No
Dire	10e. Street and Number		10	f. Zip Code			10	g. Citizen of V	Vhat Counti	ry?	
erai	719 MAIDEN CHOICE 1		42 Mac F		228	-0.4014	. Van as Na		A. e - America	n feeling	
Š	11. Marital Status 12 1 Never Married 2 Married	 Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐Ño 	lf Yes,	ecedent of H specify Cube	ispanic Origi in, Mexican,	Puerto Ric	an, etc.)		k, White, e	tc.	
2	3 AWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1 🗆 Y	es 2 No	Specify:			Specify	, W	HITE	
ted	15. Decadent's Educa	ition	16a. Decedent's	Usual Occup	ation	of working	1	6b. Kind of Bu	ısiness/Indu	ustry	
Tiple	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)		of work dorie OT use retired))	o working					
Be Completed by Funeral Director	12TH GRADE 17. Father's Name (First, Middle, Last)		SECRETA	RY	40 34-41 - 1	la Nam - 4	June Balaton - Co			COMPA	NY
De	FRANK A. SENFT						irst, Middle, M CROMWI		16)		
0	19a. Informant's Name/Relationship (Type	e. Print)	19b. Meiling Add	dress (Street					State Zin f	Codel	
			2617 MA								06
	FRANK SENFT (BROTH) 20a. Method of Disposition	20b Pla	ca of Disposition	(Name of			Date 2	Oc Location -	City or Tow	n State	00
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donetion 5 ☐ Other (Specify)	moval from Steta EVE	RGREEN M	EMORIA	L GARI	DEN 7	/13/98	FINKS	BURG,	MD	
	21. Signuture of Funerel Servica Licanses		22. Nam	and Addre	ss of Facility	HOME	TNO				
	Kinch	1					BALTIMO	RE MD	21	229	
	23a. Pert1. Enter the disease, or compiles shock, or heart failure. List only one	ations that caused the deeth.	Do not enter the	mode of dylr	g, such as c	ardiac or re	spiretory arre	st,		Approximate Interval Bety	e ween
	and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t									Onsei and E	
	Immediate Cause (Final disease or condition resulting in deeth)	6610	ISCAS	701	1A				n	s area	-18A
9	Toodiling in deality	Due to (or a	as a consequence	e of):					ĺ		
Examine	b			1 6							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequence	e of):							
Can	Cause (Disease or Injury that initiated events	Due to (or a	is a consequence	of):							
Ned	resulting in death) Last	200.00 (30.00							i		
7	d								1		
300	Part II. Other eignificant conditions contri	ibuting to death but not result	ing in the underly	ing cause giv	en in Part I.		23b. Dld tob	acco use co	ntribute to	the cause o	of death?
							1 □ Ye	2 1 No	3 Probe	ably 4 🗆	Unknown
5						-	24a. Was an	autopsy	24b. Wer	re autopsy ti	indlnas
completed by Physician/Med							perform		com	liable prior to pletion of co eath?	0
1							1 ☐ Yes	2 No		Yes 2	Ne
נ ע	25. Was case referred to medical				26. Place	of Death //	Check only one			100 2	140
2	exeminer?	spital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient 3[DOA Oth	ne. / /		5 Resider		er (Specify))	
	27. Manner of Deeth 1 SNatural 5 □ Pending	44 - 44 - 1	8b. Time of Injury	28c. Injur Wor			l. Describe how				
Call	2 Accident Investigation	i an i was i was	M		Yes 2 □ N						
medical certification; to be	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str <i>ee</i> f, fa	ctory, offica		28f	City or Town,		er or Rural	Route Num	ber,
2	20a Cartillar a Day at 1 - Dh at										
200	29a. Certifier (Check only one) 1 Certifying Phyeic 2 Madical Examinal	r: To the best of my knowler: On the basis of examinetic and menner steted.	edge, deeth occu n and/or investige	rred et the tin ation, in my o	ne, dete and pinion, deeth	place, and occurred	due to the car at the time, de	use(s) and ma te and place, a	and due to	ted. the cause(s))
2	29b. Signature and title of certifier	(/		29c. Licens	e number		29	d. Date signe	d (Month, D	Day, Year)	-
) Dent of	loops -		D	2647	3		JULY	9	1881	
	30. Name and address of person who com	pleted cause of death (Item 2	3a) (Type, Print)	1-	('			01	1)		
		BLOVS LY, M.		7A LOG	1 CF	loice	5 CANI	3, BA	17110	12621	228
	31. Date filed (Month, Day, Year)	32. Registrar's Signatur									

State Registrar

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "netural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evantmet must be notified at once.

Physician /Medicai Examiner

Baltimore, Maryland 21215-0020

JUL 1 0 1998

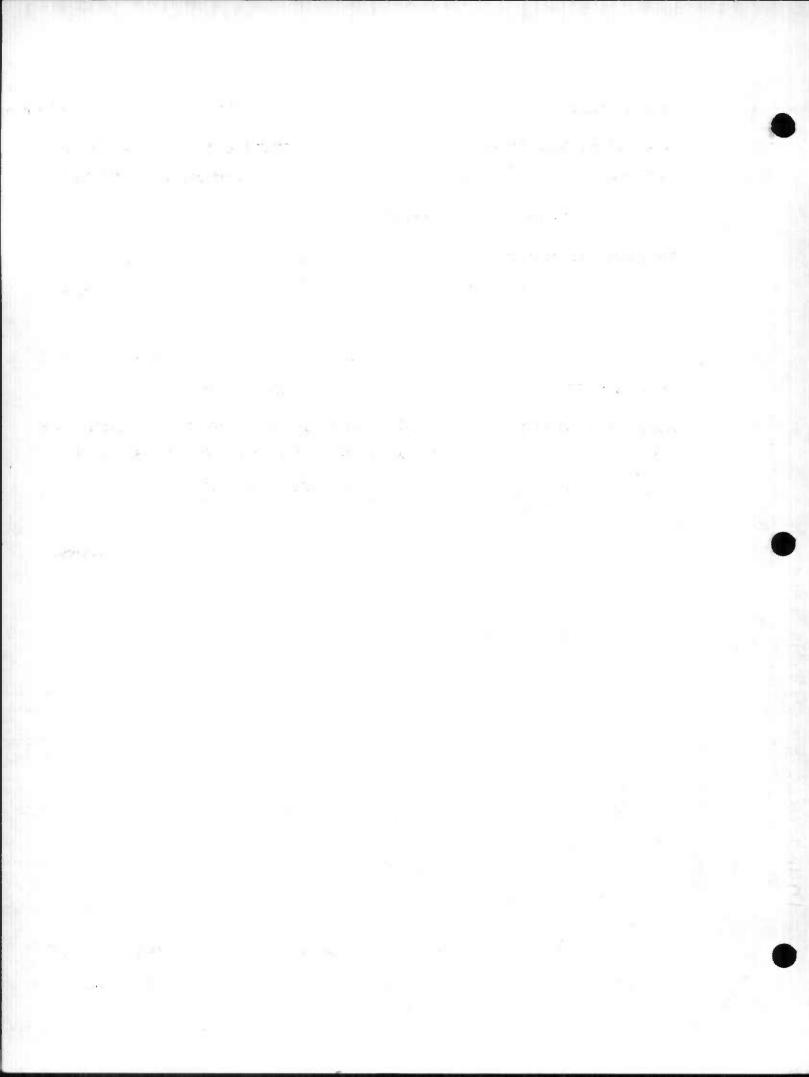
32. Registrar's Signature

To the Hospital or Attending Physician: The law requires that the death certilismithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use

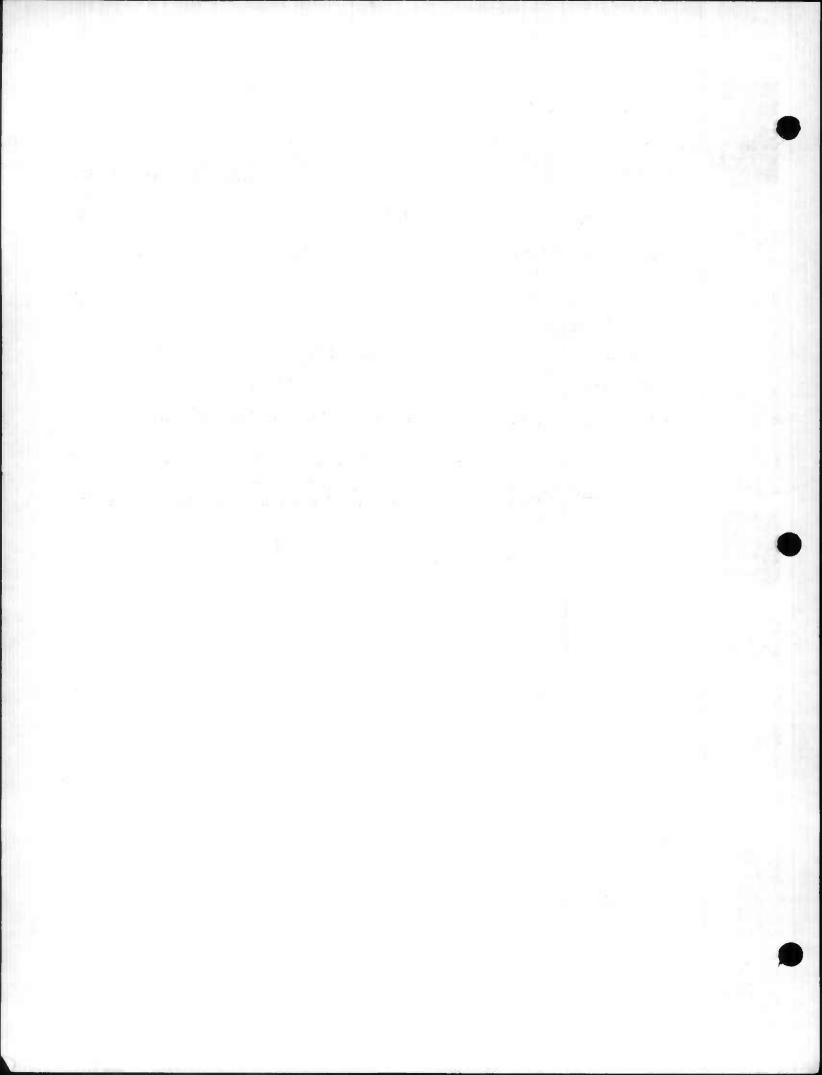
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MARY



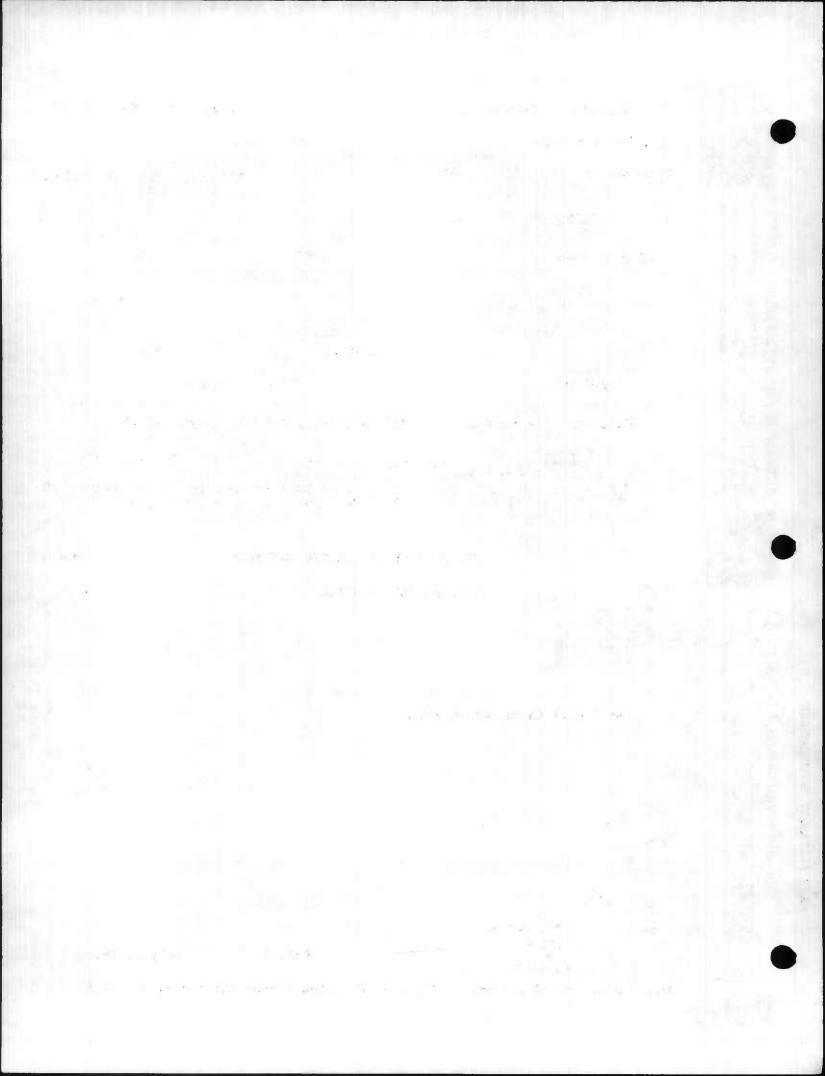
State of Maryland / Department of Health and Mental Hygiene O

									Death		Reg. No.	0 21	200		
Physic	lan	Decedent's Neme (First,) AMANDA		•						2. Dete of De Month	Dey	Yeer	Time of Death		
/Med	ical	AMANDA		IGGIN			· ·		4b. City, Town, or	July 3			15 Am		
Exam	iner	4e. Fecility Neme (If not insti													
_		Johns Hockins 6 5. Sociel Security Number	6. Se		L Can Age (In yrs.		dev) If U	Inder 1 Yeer	Baltimon	_		A Ridhalasa	(State or Enraign		
Funera Directo		215-01-8623 Usuel Residence of Decede	10	JM 2⊠F	84	Yı	Mor	nihs Deys		(Month, De	y, Year) 1, 1914	BALT	(State or Foreign		
land land		10e. Stete 10b. Co			10c. C	ity, Town	or Location	1				10d. I	nside City Limits		
Men	to	MD	/A		I	BALTI	MORE					1	Yes 2□No		
with the	i Direc	10e. Street end Number 21 N. HIGHLA	ND AV	ENUE			10	f. Zip Code	21224		10g. Citizen of V				
IN ELETISTICATION (illed within 72 hours after death with the Menyland Hygiene. ther than "natural", or items 23a or 28a-4 show mit, the Medical Examinar must be notified at	by Funeral Director	11. Maritel Status 1 Never Merried 2		12. Wes Deceder Armed Force: 1 Yes 25 If Yes, Give Yeer or Detes	s? ☑ No	J,S.			Hispenic Origin? (S ben, Mexicen, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Rac Ble Specify	ee - American Ir ck, White, etc. /: WHI			
ore, Mar ylaind ZIZID-UUZU is 1 and 2 should be filed within 72 hours aft if Heelih and Mental Hygiene, item 27 is marked other than "natural", or other traumatic avent, tra Mexical Exam	Completed	(Specify only h	- 1	ucetion le completed) College (1-4c	or 5+)	(4	Give kind o ife. DO No	OT use retire	during most of wo	rking		usiness/Industr	у		
filled v Hygie ther t		8TH GRADE 17. Fether's Neme (First, Mic	Idle Leet)				п	OMEMAK		mo /First Middle					
Maryiano d 2 should be file th and Mental Hy 7 is marked other traumatic avent	To Be	GEORGE MASON	. ,						18. Mother's Neme (First, Middle, Malden Surneme) MARY MOUCH						
Te, Mar 1 and 2 sho Haelth and em 27 is m other traum		19e. Informent's Neme/Rela			1)				t e <i>nd N</i> um <i>ber</i> or R ROAD - HA				(e)		
Caltimore, IN permit. Pages 1 end Department of Haelth Important: If item 27 any lough or other tronce.		20e. Method of Disposition			le	cemetery,		or other ple		Dete 20c. Location - City or Town, Stete RK 7/6/98 MIDDLE RIVER, MD					
artma prtant		4 Donetion 5 Oth			HO	LLY E					MIDDLE	KIVEK,	MD		
Deparition of the partition	1 Res	0	Co	2				ess of Fecility INERAL HO ENS AVENU		MORE, MD	2122	29			
Physician	Г	23e. Pert . Enter the disees shock, or heart feilure.	e, or compl List only o	licetions that ceus ne ceuse on eech	ed the dee line.	lh. Do no	t enter the	mode of dy	Ing, such es cerdia	c or respiretory e	rrest,	Inte	proximete erval Between sel end Death		
/Medical		Immediete Cause (Finel diseese or condition		Pulmon	0.01	- boli	1.5					10	days		
Examiner		resulting in deeth)	10	e. 10177077	1		nsequence	of):					0042		
ad sit	ine	b													
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X	Redical	thet initiated events resulting in deeth) Lest	1	C	Due to (d	or es e cor	nsequence	of):			·				
eath cer attendin	Physician/W			d								i i			
a dea ha at	Sici	Pert II. Other significant con	ditiona co	ntributing to death	but not res	sulting in t	he underly	ing cause gi	ven in Pert i.	23b. Did	tobacco uae co	ntribute to the	cause of death?		
es that tha de igned by tha a	by Phy	breast cancer								10	Yes 2□No	3 Probably	y 4⊠Unknow		
aw raquin is been s 2 should	Completed b			-							en eutopsy ormed?	aveileb	utopsy findings le prior to tion of cause h?		
	Con									10	Yes 2 No	1 □ Ye	s 2KNo		
ysician: The scartificate director, pag	Be	25. Wes cese referred to me exeminer?						1-		eth (Check only	one)				
Physician: this cartific	2	1 Yes 2⊠ No	,	lospitei: 1 ☑ Inpa		ER/Outp		LOOA		lome 5 Resi					
D 9 2	ation:	E C MOOIGOIII	estigation	28a. Dete of In (Month, E	ijury Day Year)	28b. Tin Inju		28c. Inju Wo	nyet ork?]Yes 2□No	28d. Describe	how Injury occur	red			
tal or Attending rs after death. al Director: After	Certification:	3 Suicide 6 Co 4 Homlcide de	uld not be ermined	28e. Plece of I building,	njury - At h etc. <i>(Speci</i>	ome, ferm	n, street, fe	ctory, office		28f. Location (City or To	Street end Numb wn, State)	per or Rurel Ro	ste Number,		
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	edicai	29e. Certifier 1 Cart (Check only one) 1 Med	fying Phys cat Exami	ner: On the besis end menner:	of exemine	owledge, o	deeth occu or Investige	rred et the ti etion, In my	ime, dete end plece opinion, deeth occu	e, end due to the urred et the time,	ceuse(s) end mi date end plece,	enner as steted end due to the	ceuse(s)		
within 2 To the compla	M	29b. Signature end lilie of ce	tifier		_			29c. Licen	se number	T	29d. Date signe	d (Month, Day,	Year)		
		30. Name and address of par	SeSe	ng	I dacib th	m 00-1 (T	D	RE	SODI		July 6, 19	98			
2		PATIENCE	AG	BORBE	SON	9	JOH JOH	tNS	HOP KIN	US BAY	VIEW				
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DHMH 16 Rev 6/95

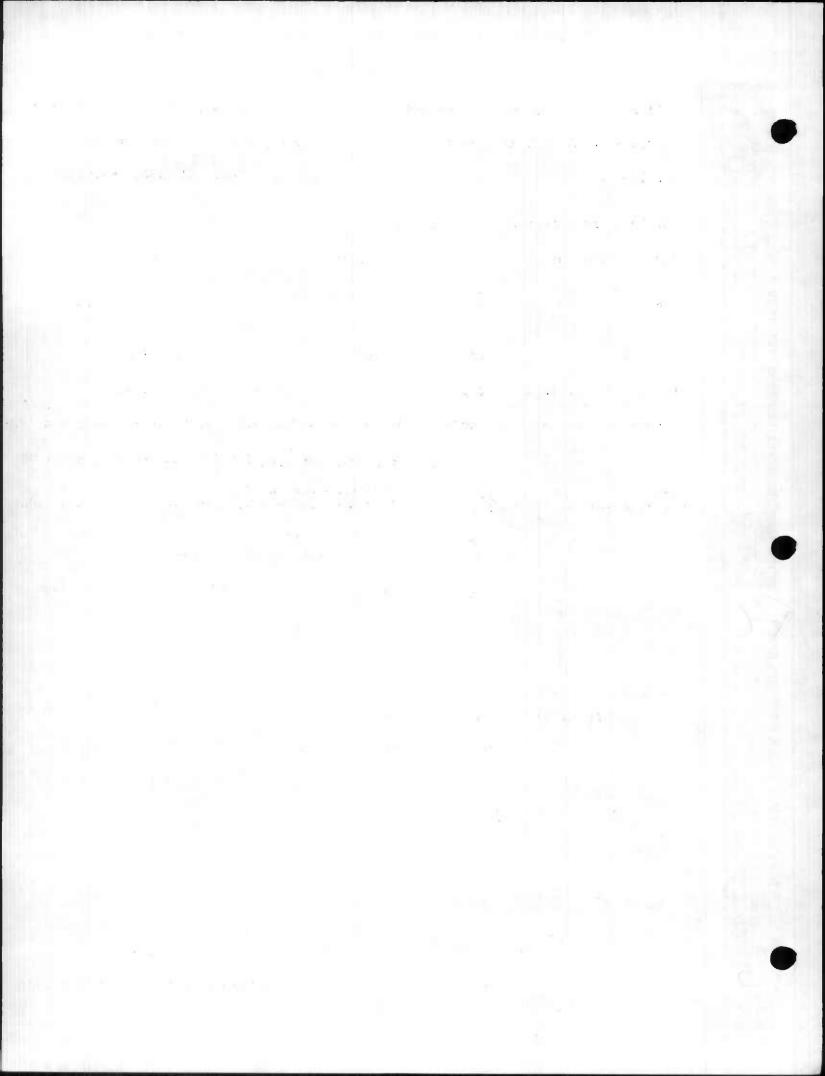
ician	1. Decedent's Nar	me (First, Middle	, Last)					2. Dete of D		Year	3. Time of Death	
ical	Mary E	lizabet	n Rosenbe	erger				July	7 19	998	18:21 PM	
ner	4a Facility Neme	(If not institution	, give street end n	um <i>ber)</i>				r Location of Dea	th 4c. County	of Deeth		
		nes Hos				WT1	Baltim			V/A		
	5. Sociel Security		6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hi Hours Min	n. (Month, D			plece (State or Foreigntry)	
	053-28- Usual Residence		^	65	114			AUG. 2	7, 1932	Per	nnsylvania	
	10a. Stete	10b. County		10c. City	, Town or Loca	tion			10d. Inside City Lim			
	Md.	Balti	more	N/A							1 ☐ Yes 2 No	
חפרוס	10e. Street and No	umber				10f. Zip Code			10g. Citizen of	What Coul	ntry?	
I	1947 Be	ell Aver	7				1227		USA			
		rried 3(X Marri 4 □ Divorced	Armed F	2)() No Give	if Y	es, specify Cub	an, Mexican, Pue	(Specify Yes or N arto Ricen, etc.)	No- 14. Race - American Indien, Biack, White, etc. Specify: white			
	(Sne	15. Decedent	's Educetion t grade completed	0	16a. Deceder	nt's Usual Occup	pation	rorkina	16b. Kind of B	usiness/In	dustry	
	Elementery/Sec	condary (0-12)	T	(1-4or 5+)		NOT use retire	during most of w		Food	4		
	17. Father's Name		and)	4	DI	ECTCION	19 Mother's N	ame (First, Middle				
		oy Bear					1	E. Hrest				
	19a, informant's N	Name/Relationsh	nip (Type Print)		19b. Mailing	Address (Stree	t and Number or i	Rural Route Num	ber, City or Town,	State, Zi	c Code)	
			er - hus	band				imore, N				
	20a. Method of Di	sposition		20b. P	lace of Disposit	ion (Name of		Date	20c. Location	City or To	own, State	
		2 ☐ Cremation 5 ☐ Other (Sp	3 □Removai from secify)	n State	dowridg		Park	7/10/98	Elkrie	dge,	Md.	
	21. Signature of F	unerei Service I	icensee	7	22.1	leme end Addre	ess of Facility	7 11	0.11	1.	. I MD	
	(X	anue	104	10 KQ				neral Ho			1age MP 21075	
	23a. Part1. Enter	disease, or	complications thet	caused the deeth	. Do not enter	the mode of dy	ng, such es cardi	iac or respiratory	errest,	iu.	Approximate interval Between	
1	23a Partt Ener the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or have failure. List only one cause on each line.											
Immediate Cause (Finel disease or condition a RUPTURED THORACIC AORTIC ANEURYSM											Minutes	
resulting in death) Due to (or as a consequence of):									1			
			b	CARDIOVA					Years			
	Sequentially list of	onditions, immediate		Due to (o	r as a conseque	ince of):						
	if eny, leeding to											
	Sequentially list of if eny, leeding to ceuse. Enter Und Ceuse (Disease of the initiated even	or Injury 👚	C	Due to (or	ac a concequie	nce of):				-	-	
	Ceuse (Diseese o	or Injury	c	Due to (or	as a conseque	nce of):			. 4			
	thet initiated even	or Injury	c	Due to (or	as a conseque	nce of):						
	thet initiated even	or Injury its) Lest	d				ven in Pert i.	23b. Did	i tobacco use co	ontributs t	to the cause of death	
	Part ii. Other sign	ificant conditio		deeth but not rest	ulting in the und		iven in Pert i.		d tobacco use co]Yes 2□ No	ontributs 1	V	
	Part ii. Other sign	ificant conditio	d	deeth but not rest	ulting in the und		wen in Pert i.	10	Yes 2□ No	3 □ Pro	obably 4 Unknow	
	Part ii. Other sign	ificant conditio		deeth but not rest	ulting in the und		iven in Pert i.	1 [24a. Wa		3 □ Pro	bebly 4 Unknown	
	Cause (Disease of that initiated even resulting in death) Part II. Other sign	ificant conditio		deeth but not rest	ulting in the und		iven in Pert i.	1 [24a. Wa per	Yes 2 No	3 □ Pro	dere autopsy findings vailable prior to mplefion of cause death?	
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State of Maryland / Department of Health and Mental Hygiene

					Certificat	e of	Death		Reg. No. 9 8	3	1258	
		1. Decedent's Neme (First, Middle, Las.	t)					2. Dete of Dee		Yeer	3. Time of Death	
	Physician /Medical	Gladys Gert	rude I	Ringgol	d			July 7		1 001	8:30 PM	
9	Examiner	4a Facility Name (If not institution, give					4b. City, Town, or L			of Death		
		Anne Arundel Me	dical Cent	ter			Annapo	lis	Anne	Arund	lel	
	Funeral	Sociel Security Number 6. Se		(In yrs. last bii	thday) If Under	1 Year Deys	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h (Year)	9. Birthple	ace (Stete or Foreign	
ב	Director	218-14-5920 Usuel Residence of Decadent	□M 2 <u>X</u> 0 F	94	Yrs.	Doys	110013		22, 1903		yland	
Jano	M M	10a. Stete 10b. County		10c. City, Tow	n or Location					10	d. inside City Limits	
N S	to of	Maryland Anne Ar	undel	Seve	rn						1 ☐ Yes 🕺 🖾 No	
e i	or 28a-f all be notified Director	10e. Street end Number			10f. Zip	Code		10g. Citizen of Whet Country?				
h wit	Sa o	1276 Delmont Road			21	144			U.S.	Α.		
dead	r items 23s iner must Funeral	11. Meritel Status	12. Wes Decedeni E	Ever in U,S.			fispanic Origin? (Sp en, Mexican, Puerto	ecify Yes or No-	14. Raci	- America		
21215-0020 within 72 hours efter death with the Maryland	"natural", or frame 23e or 28e-1 ahow edical Exarcher must be notified at leted by Funeral Director	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes ② N If Yes, Give Year or Dates:	io	1 Yes			rican, etc.)	Specify	k, White, e		
6 5	De letter	15. Decedent's Edu		16a	. Decedent's Usue	el Occup	pation	. 1	16b. Kind of Bu			
E 57		(Specify only highest grad			(Give kind of wo	rk done se retire	during most of work d)	ing				
2121 1 within	r than	12	College (1-4or 5- N/A	+)	Teller				Bankin	g		
The Police	T 2 5 0						18. Mother's Nem	e (First, Middle,	Maiden Sumem	e)		
- 0	Menta arked c aric ev	Luther Elbrid	ge Cla	ark			Lillie	Має	Та	se		
aryla	s ma	19e. Informant's Name/Relationship (T	ype, Print)	19b	. Meiling Address	(Street	end Number or Rus	el Route Numbe	or, City or Town,	Stete, Zip	Code) 21061	
	5 - 5	Beverly Kueth	e (Daughte	er) 7	00 Glenv	iew	Avenue S	.W. G16	n Burni	e, Ma	ryland	
0 -	£ 5 5	20e. Method of Disposition		20b. Piece o	f Disposition (Nerry, crematory or o	ne of	ce)	Dete	20c. Location -	City or Tov	wn, State	
Baltimore,	ont of of or of or or or	1 Buriel 2 □ Cremetion 3 □ I 4 □ Donation 5 □ Other (Specify,		Glen	Haven Me	mori	al Park	7/10/98	Glen Bu	rnie,	, Maryland	
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^		resulting in death)		Due to (or es a	consequenca of):							
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ecords, P.O.	ate hes been signed, page 2 should be d							24a. Was	an autopsy	24b. We	ere autopsy findings	
000	should should	CALCIE	cic Aon	TIC V	WARE	012	CHU	perfo	rmed?	cor	elleble prior to appletion of cause death?	
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Division	rs after death. all Director: After to led in by the funera Certification:	2 Nacident investigation 3 Sulcide 6 Could not be determined	28e. Pleca of Inju building, etc	ıry - At home, fa :. (Specify)	arm, street, fector	y, office		28f. Location (3 City or Tox	Street and Numb vn, Stete)	er or Rura	I Route Number,	
Hospital	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of	examinetion er								
£	who is the lamble maple l	one) 29b. Signeture and title of cartifier	end manner sta	ted.	20.	n I inan	se number		29d. Date signe	d (Moleth	Day Yearl	
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L)	30. Name and address of person who c			ΛΑ	0			1	1		
		GENANN 31. Dete filed (Month, Par Year) 10	CHUN 32 Berliste	r's Signature	11, 1),	8 EVERGRE	EN ROAD	, SEVER	NA PA	RK,MD.21146	
	State	are note that the state ball today	AMM OE. LIGHTON	A A A S. INCOLOR	70 .							

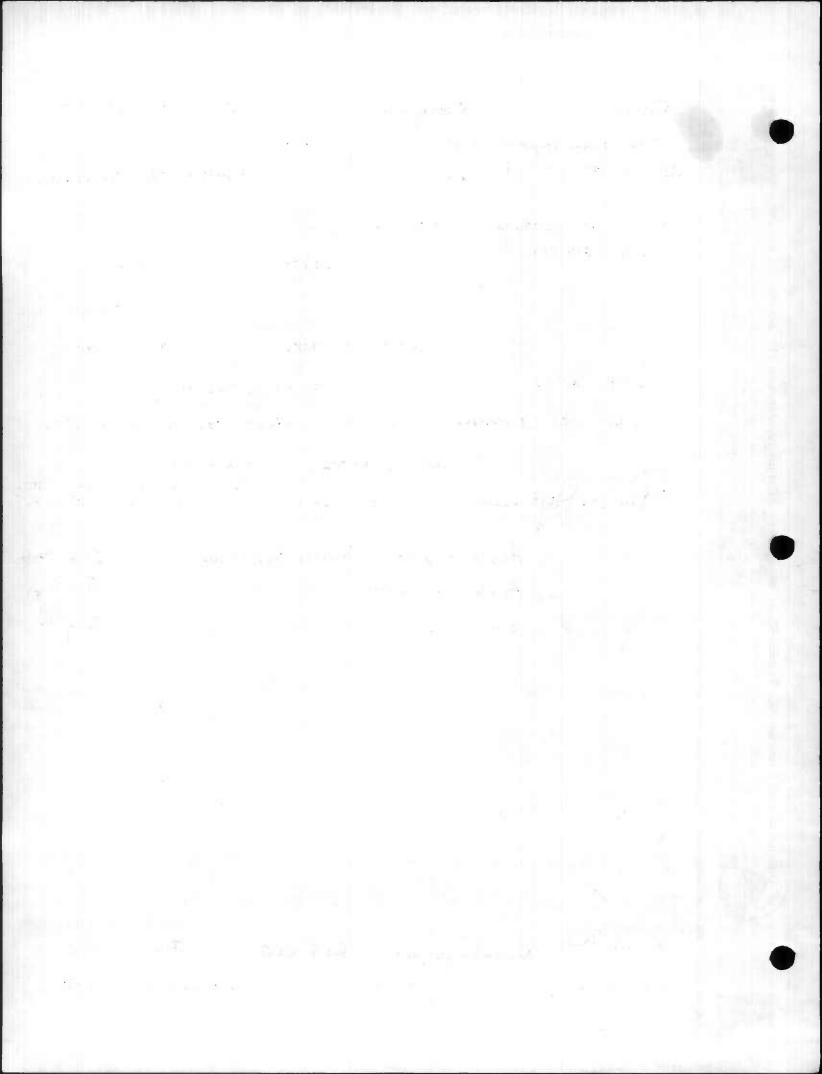
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 21259 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Physician 1719 Sharon Kamagnano June 1998 25 /Medical 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY The Johns 6. Sax Hospital If Undar 1 Yaar | If Undar 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** 1 ☐ M 2 💢 F 219-80-1053 Director 08-10-1957 Balto.Md. Usual Rasidanca of Decedant the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "netural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at 1 Yas 2 No Director Md. Anne Arundel Edgewater 10f. Zip Coda 10e Street and Number 10g, Citizan of What Country? death with 3661 2nd Avenue Funeral 21037

13. Was Decedant of Hispanic Origin? (Specify Yas or NoIf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 4. Aace - Amarican Indian, 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 No 11 Marital Status Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or thei any injury or other traumetic event, as Medical Examines. 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☐ No Spacify: Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 € Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Etamantary/Secondary (0-12) Collega (1-4or 5+) Restaurant Mgr. Restaurant 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be William Jarboe Janet C. Zeller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Janon Bowdin, DAUGHTER 727 South Montford Ave., Balto. Md. 21224 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2X Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metro Creamtory 6-26-98 Balto, Md. 22. Nama and Addrass of Facility Ambrose Funeral Home, Inc. Spring Rd. Balto. Md/21227 1328 Sulphur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only of a cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in deeth) /Medical . Acute Respiratory Distress Syndrome Examiner Examiner Pancreatitis physician and the burial-transit Sequentially list conditions, if any, taeding to immadiata ceusa. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last Ethanol Box 68760. Use Physician/Medical Dua to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the causa of death? Part It. Other algnificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown on of Vital Records. þ 24b. Wara autopsy findings availabla prior to complation of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa referred to medicel axaminar? Be 26. Placa of Daath (Check only ona) Hospitel: 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 ☐ Yes 3 No 10 28a. Data of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of tnjury 28d. Describe how Injury occurred 28c. Injury at Work? 5 Panding Invastigation 1 Natural 2 Accident 1 ☐ Yas 2 ☐ No Divis 6 Could not be datarminad 28a. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 281. Location (Straat and Number or Rural Route Number, City or Town, State) 3 Sulcida 4 Homloida 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 29a. Cartifiar (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifiar 29d. Data signed (Month, Day, Year) 29c. Licensa number June 25, 1998 RES-000 Nutro herger and 30. Name and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print) 600 N. Wilfe St., Beltimore MD Nuermberger MI) Tower 110 31. Date filed (Month, Day, Year)

JUL 1 0 1998 Julia Davidson-Randall 32. Ragistrar's Signatura State

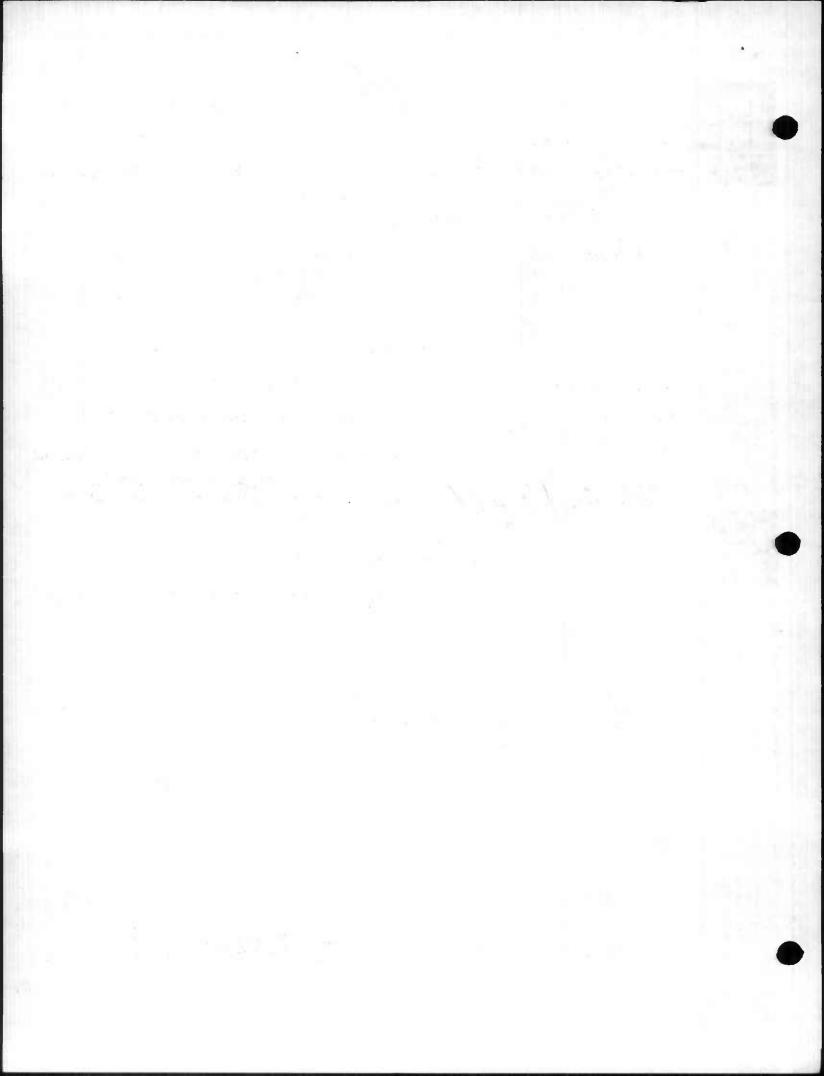


State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death July 5, **Physician** 3:00 PM Anna Razwell /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4104 Roland Avenue Baltimore Baltimore 5. Sociel Security Number If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 2/25/1914 9. Birthplace (State or Foreign Country)
Pennsylvania 7. Age (In yrs. lest birthdey) **Funeral** Deys 1□M 2□F 070-14-7703 84 Yrs Director Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at Baltimore MD Baltimore Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21211 U.S.A. 4104 Roland Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Dates: 14. Race - American Indian, Bieck, White, etc. 11 Meritei Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) filed within 72 hours efter Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. the Means in Item Inc. Eiementery/Secondery (0-12) Coilege (1-4or 5+) Homemaker Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Stobodzan Christina Lis Dmitri 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 4104 Roland Avenue Baltimore, Maryland 21211 19e. Informent's Name/Relationship (Type, Print) Laura ODell 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriei 2 ☐ Cremation 3 ☐ Removal from State 7/9/1998 Baltimore, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Dippel Funeral Home Inc. 21. Signature of Funeral Service Licenses 7110 Belair Road Baltimore, Maryland 21206 23a, Part1. Enter the disease, or complications shock, or heert feilure. List only one ceusi he death. Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximate Interval Between Onset and Death caused eech line **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or es a consequence of): man physician end the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence ot): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? signed by 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 Unknown by 24b. Were autopsy findings evallable prior to should should Completed 24a. Wes en eutopsy performed? completion of cause of death? ate has page 2: 1 Yes 1 ☐ Yes 2 ☐ No certificate of Vital Be 25. Was cese referred to medical exeminer? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28e. Dete of Injury (Month, Dev Year) 28c. Injury et Work? Division 1 Naturei 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 29a. Certifier 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. within 2 To the To the 29c. License sumbe 29d. Date signed (Month, Dey, Year) 29b. Signature endititle of certifier 98 6 30. Name and eodin ss of person who completed ceuse of death (Item 23a) (Type, Print) 5601 Lock BAHMORE, Md PERAL 31. Dete filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

JUL 1 0 1998

2. Registrar's Signature



98-3703-510 B.K.S

BOBBY ROSS

Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Birthplace (Stata or Foreign Country)

10d. Inside City Limits

Approximate Interval Betwe Onset and Death

4 Unknown

24b. Were autopsy findings available prior to

er or Ayral Aouta Number.

completion of cause of deeth? Yes 2□ No

1 ☐ Yes 2 ☐ No

3. Time of Death

1316 PM 4c. County of Death

Funeral

the Manylenc ir than "natural", or flame 23a or 28a-f show the Medical Examiner must be nothled at

2 should be filled within 72 hours effer and Mental Hygiene.
Is marked other than "natural" or Hau pémit. Pages 1 end 2 Deportment of Health a Important: If Nem 27 Is any Injury or other trai page.

altimore.

Physician /Medical Examiner

this

funeral After efter death. Director: Aft ò 24 hours To the I within 2

Physician /Medical Examiner **Director** Directo Funeral þ Completed Physician/Medicai Examiner þ Completed

2. Date of Deeth 1. Decedent's Name (First, Middle, Last) JUNE 28, Dey 1998 BOBBY ROSS F. 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) N/A JOHNS HOPKINS HOSPITAL E.R. BALTIMORE If Under 1 Yeer 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□M 2□F Months Days Hours Yrs. 218-17-2834 24 APRIL 17,1974 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1810 BARCLAY ST. 21202 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: NFGRO 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10TH N/A UNEMPLOYED N/A 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Malden Sumama) GEORGE F. ROSS INEZ **AGNEW** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) INEZ ROSS 1810 BARCLAY ST. BALTO, MD. 20b. Plece of Disposition (Neme of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) VOSHELL MEMORIAL PARK JULY 6, 1998 BALTO, MD. 22. Name end Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 04 1412 E. PRESTON ST. BALTO, MD. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21213 23a. Part1. Enter the disease, or complications that cause in shock, or heart failure. List only one ceuse on each Immediate Ceuse (Finel disease or condition resulting in deeth) val of Chart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Lest Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 24e. Was en eutopsy performed? 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 X Yes 2 □ No 1 Inpatient 20 ER/Outpatient 3 DOA 28c. Injury et Work? 28d. Describe how Injury occurred 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural 5 Pending 128/98 1 Yes 560 investigation 2 Accident 55 14A 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 4 13 Homicide Start Federal Street Actions

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as at eted. 29a. Certifier Medicai 2XXInedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signature and title of certifier

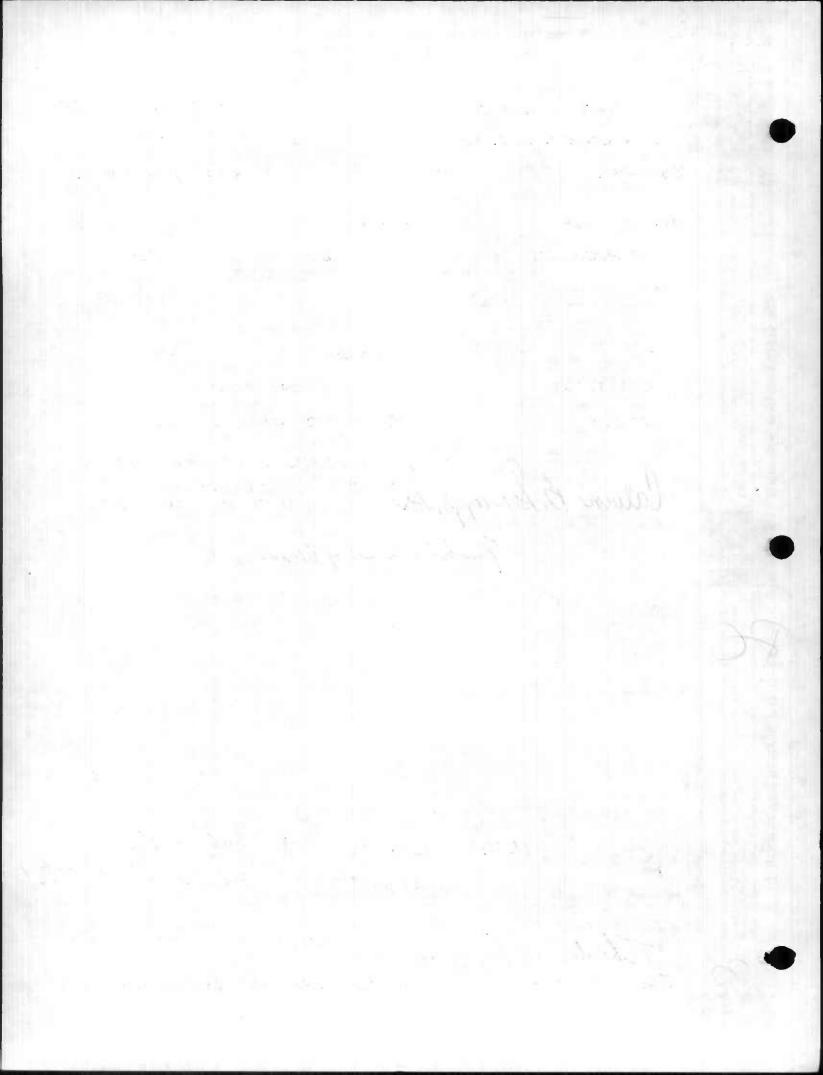
THEODOREM. KIND UL TO 19

29d. Date aigned (Month, Day, Year) 29c. License number JUNE 28 , 1998 O.C.M.E

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 32. Registrer's 6ignature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 958PM 5 Cott **Physician** WKEI E 98 /Medical APT-403A Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner the of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state o zaraen IMOTE 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs. 9 Birthplace (State or Foreign **Funeral** Hours 1 M 2 F Months Days Min. Director ginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d, inside City Limits Maryland 1 Yes 2 □ No Directo imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 403A 212 Garden 20 Funeral ane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American indian. h and Mental Hygiene. 7 is marked other than "natural", or flen treumedo event, the Medical Examiner. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Blac þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) auard 17. Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Iami 19a. Informant's Name/Ratationship (Type, Print) (daughter) 19b. Mailing Addrass (Street and Number rte Number, City or Town, State, Zip Code) 1209 Mrs. Carol Item 27 Itor 066 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility JOSEPH L. KH 2222 W. North 21. Signalure of Funeral Service Licensee Funeral SS Little the desase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Balto. Approximate Interval Between Onset and Death Physician Immediata Causa (Final disease or condition resulting in death) Myocardia Intarction /Medical Examiner Mellitys iabetes Examiner The law requires that the death certificate be executed attending physician and for use as the buriaf-transit Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or injury that initiated evants resulting in death) Last berton sion P.O. Box 68760. Physician/Medical Cardio vascular Diseas Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Blindhess 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? 2 Loiners Completed Discare completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only ona) 1 Yes 2NNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 28a. Data of injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: Affect or Attending 1 Natural 5 Panding invastigation death. 1 Yes 2 No 2 Accident after death Director: 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homlcida Certifying Phyeiclan: To the best of my knowladga, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the causa(s) and manner stated. edical (Check only one) ŝ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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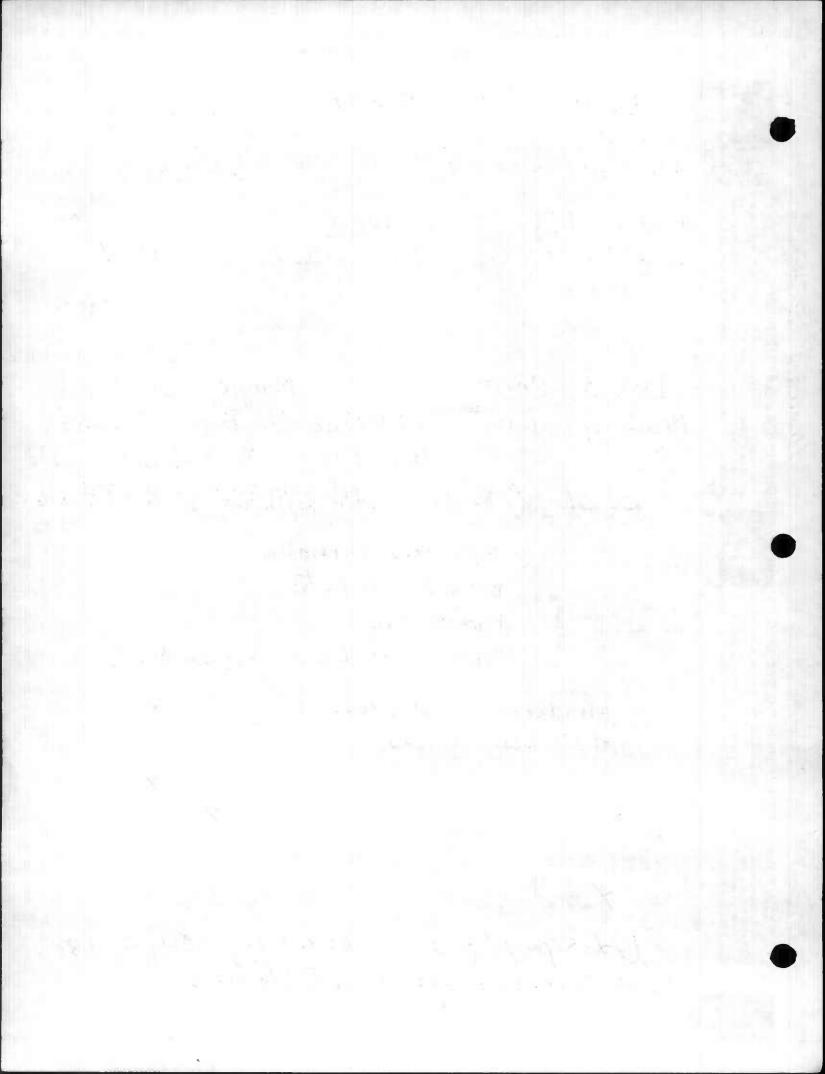
30. Name and addrass of person who completed cause of death (Item 23a) (Type, Brint) 15 90 Balto

32. Registrar's Signatura

State Registrar 31. Date filed (Month, Day, Year)

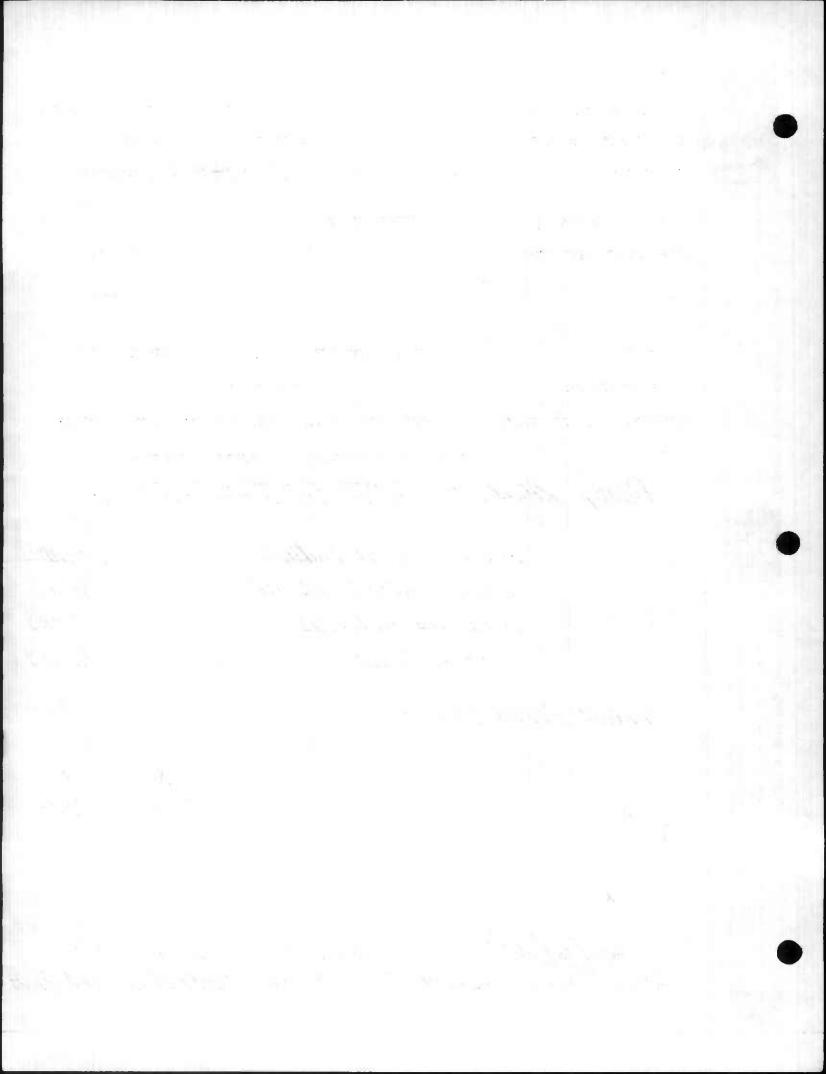
DHMH 16 Rev 6/95

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uneral irector	5502 HARRIS FAR 5. Social Security Number 213-09-7450 Usual Residence of Decedent		ım <i>ber)</i>				JULY 08			8:00PM	
irector	5. Social Security Number 213-09-7450 Usual Residence of Decedent	M ROAD				4b. City, Town, or		4c. County			
irector	213-09-7450 Usual Residence of Decedent	6. Sex	7. Aga (In yrs. la	ast hirthdowl	If Under 1 Yaar	CLARKS\ If Under 24 Hrs			WARD	(Cana F '-	
there 23e or 28e-f show ther must be nothed at Funeral Director			91	Yrs.	Months Days			, Year) .906	Count MARY	ace (Stete or Foreig try) LAND	
thems 23a or 28a-f shi ther must be notified a Funeral Director	10a. State 10b. County		10c. City,	, Town or Loc	cation			Od. fnside City Limits			
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ther must be ther must be funeral Di	10e. Street and Number				10f. Zip Code			Og. Citizen of N	What Coun	trv?	
iner mu	8806 AUTUMN HIL	L COURT				21043			U.S.		
5 E	11. Maritai Status	12. Was Dac	edani Ever in U,S		Vas Decedent of I	Hispanic Origin? (S	Specify Yes or No-		e - America	an Indian,	
by I		If Voc Ci	2∕∑ No ve		Yes, specify Cub	Specify:	to Rican, etc.)		ck, White, e		
ted tes	15. Deceder	t's Education		16a. Deced	ent's Usuel Occu	pation		16b. Kind of B	usiness/Ind	ustry	
t, the Medical Completed	(Specify only higher Elementary/Secondery (0-12)	st grada completed) College ((Give A	kind of work done OO NOT use retire	during most of wo	rking				
De la	12	College (1-401 5+/	CLAIM	ADJUS	TER		RETA	AIL S	ALES	
outher event, Be Co		Last)				18. Mother's Na	me (First, Middle,	Malden Sumen	ne)		
aumatic eve To Be	ROBERT KILBOU	RN				ANNA MAY	HANN				
E S	19a. Informent's Name/Relations	hlp (Type, Print)		19b. Meiling	g Address (Street	t end Number or R	urel Route Number	r, City or Town,	Stete, Zip	Code)	
em 27 la other tra	RANDOLPH F. SMI	TH, JR./S	ON	8806 F	AUTUMN H	ILL COURT	r, ELLICO	TT CITY	Y, MD	21043	
r other to	20a. Method of Disposition			aca of Dispos	sition (Neme of netory or other pla	ace)	Dete	- City or Town, State			
7 or	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donelion 5 ☐ Other (5		State		RK CEMET		7/13/98	BALTIN	ORE.	MD	
Important: If I any injury or once.	21. Signature of Funeral Service				Name and Addre		.,,	212222	1014	-	
any ir	Pan.	Atai	7	SI	TERLING A	ASHTON FU	JNERAL HO	ME, INC	C.		
	23a Part 1 Enter the disease of	complications that	caused the death			DSON AVE.			4D 212		
	23a. Part1. Enter the diseese, or shock, or heart tailure. List	only one ceuse on e	ech line.	. Do not ente	a the mode of dyl	ng, such as cardia	c or respiratory en	est,	1	Approximate Interval Between Onsal and Death	
sician edical	Immediate Ceuse (Final	A	1 =0	- d/s	-nnt 1	un:hin				1	
miner	disaasa or condition resulting in death)	e. CONG				AiAURE			4	MOLUN	
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ansit mir	E D. LICHENIC PHENKI WISEASE									TLITES	
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physicia s the bur										TENKO	
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al Director: After t ed in by the funera Certification:	2 Accident Investi 3 Suicide 6 Could	not be	of Injury - At hon	ne farm stra			28f. Location (S	reet and Numb	er or Rural	Route Number	
Director: d in by the ertifical	4 ☐ Homicide determ	buildi	ing, etc. (Specify))	iot, lactory, offica		City or Town			riodio riumbor,	
0 0		g Physician: To the	heet of my knowl	dedge death	accurred at the ti	me, data and place	and due to the e	ouse/s) and me	nn or or ot	atad	
pletely fi edical	(Check only 2 Medical one)	Examiner: On the bi	asis of exemination	on and/or inve	estigation, in my	opinion, death occi	urred et the time, d	ate end plece,	end due to	the ceuse(s)	
To the Funeral Director: completely filled in by the Medical Certifical			, constant		29c. Licens	se number	2	9d. Data signe	d (Month, L	Dey, Year)	
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	N		an of donth /Hom !								
	30. Neme and address of person	who completed caus	se of death (item)	23a) (Type, P	rint)	wa pr	1 AID	DUDIVI	110	MD 21	

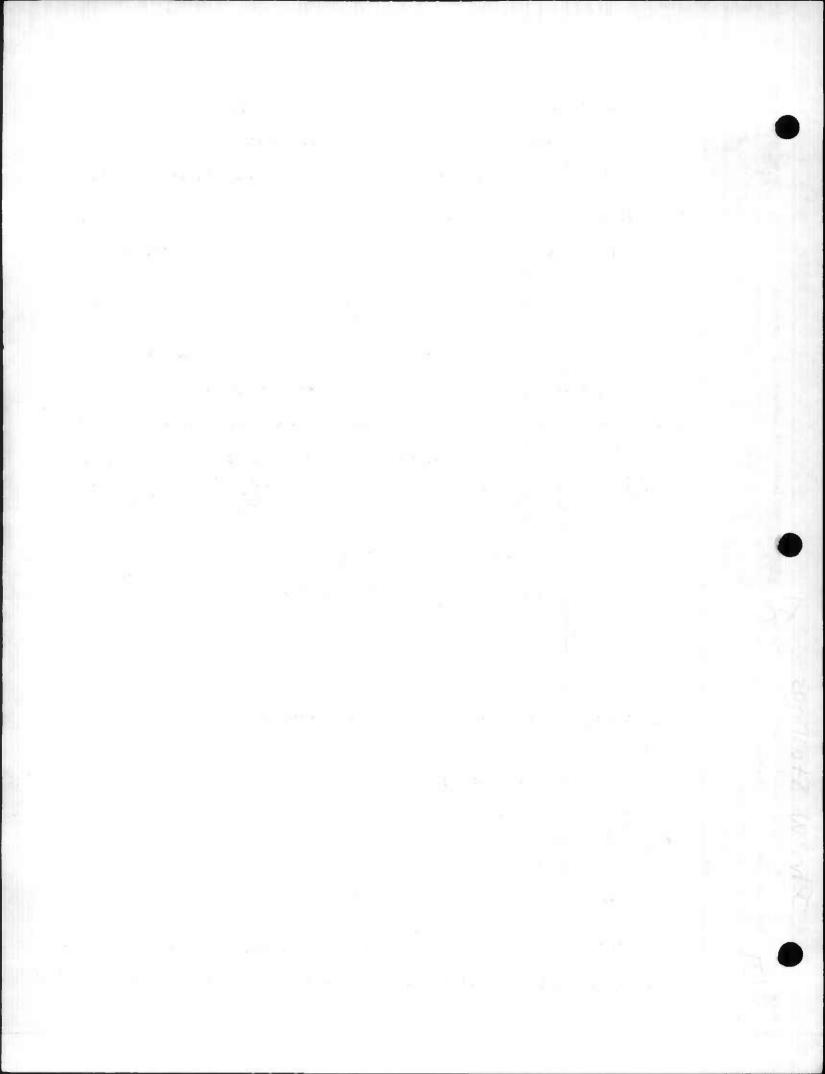
DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene 21264 Certificate of Death 1. Decedent's Nama (First, Middle, Lest) 2. Date of Death 3 Time of Deeth JULY **Physician** John W. Stallings 4:35 pm 0 1998 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2 □ F Months Days 69 218-22-7142 Yrs Director 1928 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland n/a Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whel Country? 2812 Miles Avenue 21211 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marifal Stafus permit. Peges 1 and 2 should be filed within 72 hours efter Depertment of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or ite mortant if item 27 is merked other than "natural", or item and jujury or other traumatic event, ite Medical Examina page. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorcad Year or Dates: Completed 15. Dacadent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 8 Supervisor machinery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 Dr. John W. Stallings Francis Barnesly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Anna Jarrett - cousin 15606 Wild Rose Court, New Windsor, MD 21776 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 7/10/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home Funeral Service Licensee 3620 Wilkens Avenue Baltimore, MD 23a. Pert1. Enfer the disease, or complication that caused the death. Do not enfer the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final a. End stage colon Six years disease or condition resulting In death) **Examiner** Physician/Medical Examiner Three months 6. Chrpnic Lymphocytic burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (of as alconseque Box 68760, that Initiated events resulting In deeth) Last the Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Esophagitis 1 Yea 2 No 3 Probably 4 Unknown 4. Adult Marasmus 2 2 24b. Were autopsy findings evailable prior to page 2 should 24a. Was an autopsy performed? poquicemi completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No enal Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident ofter deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homlcide To the Hospital
within 24 hours e
To the Funeral 29a. Certifier 1⊠ Cartifying Physician: To the best of my knowledge, death occurred et the time, data and placa, and due to the cause(s) and manner as stated.
2□ Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and fitle of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) July 107/1998 AT2438946 tanan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Union Memorial Hospital 201 E-University PKway, Baltimore, MD21218 Union 31 Registrar's Signature Julia Davidson-Gandalle State

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death Dev **Physician** Month 8:30 A.M. Michael Everett 4b. City, Town, or Location of Deeth Setser /Medical 1998 4e. Facility Name (If not institution, giva street end number) 4c. County of Deeth **Examiner** 216 B Woodhill Drive Glen Burnie

If Under 1 Yaar | If Under 24 Hrs. | 8. Deta of Birth (Month, Dey, Year) Anne Arundel 5. Social Sacurity Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Deys 234-82-0861 1⊠M 2□ F 47 Yrs. July 25, 1950 W. Virginia Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel 1 Yes 2 No Director Glen Burnie 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 216 B. Woodhill Drive 21061 United States 12. Wes Decedent Evar in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, atc. 1 ☑ Yes 2 No 1970-If Yes, Give Yaar or Dates: 1971 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Transporation 12 Truck Driver 17. Fethar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Everett R. Setser Lucy Hudnell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Naomi L. Setser/Wife Woodhill Drive Glen Burnie, MD 21061 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory July 10, 1998 Catonsville, MD 21. Signeture of Funeral Service Licensee 22. Neme end Address of Facility Kirkley-RUddick Funeral Home 421 Crain Hwy, S.E. Glen Burnie, MD 21061 23a. Pert1. Enter the disaase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shook, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Ceuse (Finel e. ISCHEMIC CARDIOMYOPATHY diseasa or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Physician/Medical Dua to (or es e consequance of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy tindings available prior to Completed 24a. Wes an eutopsy complation of cause of deeth? 2 X No 1 Yas 2 No 25. Wes case referred to medical exeminar? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation Neturel 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street end Number or Rural Routs Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Medical Tertifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end menner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. Licansa number

BALTIMORE, MD 21287

P.O. Box 68760, Records, Division of Vital the Hospital or Attending Physician: hin 24 hours after death. within 24 hours a

certificate

this

After

Director

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Maxical Examinar must be notified at

should be filed within 72 hours effer ond Mental Hygiene.

marked other than "natural", or ite

permit. Pages 1 and 2 should be file.
Department of Health end Mental Hy, Important; If Nem 27 Is marked other any Injury or other the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the

Physician /Medical

Examiner

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altimore, Maryland 21215-0020

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State Registrar

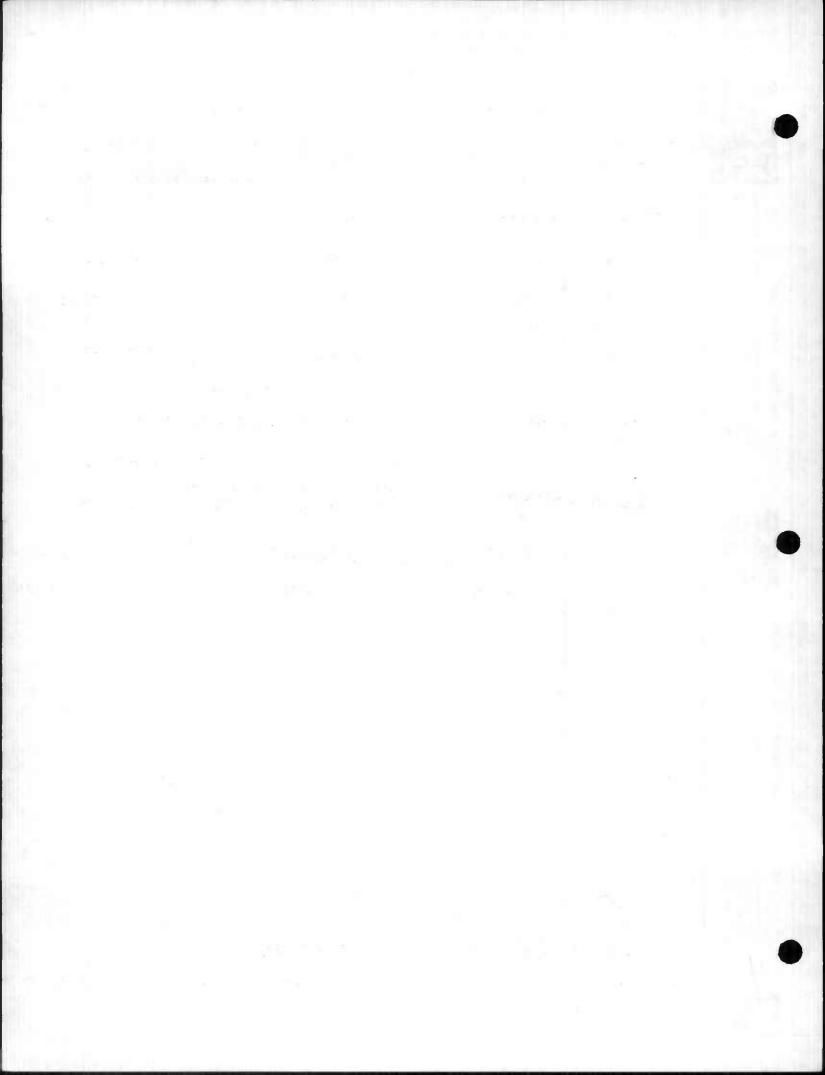
PAK, 31. Dete filed (Month, Dey, Year)

THE JOHNS HOPKINS HOSPITAL, 32. Registrer's Signeture white Savidson

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MD

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental

Hygiene	98	21	26	6
Reg. No.		-		

ELLWOOD AVE, BACTOMD 21224

Item 26 Per Phy Film G761 7-10-98 rja Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Florence Lavinia Speca 8, July 1998 1:12pm /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 4236 Darleigh Road Perry Hall Baltimore 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 10/6/1914 7. Age (In vrs. last birthdey) Birthplaca (Stete or Foreign
Country) **Funeral** Months Days Hours Min 1 M 2 DCF 83 Yrs. 213-34-9769 Director Maryland Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow adical Exampler must be notified at MD 1 Yes 2 □ No n/a Director Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3403 Claremont Street 21224 USA d 2 should be filled within 72 hours efter deeth th end Mental Hygiene.
7 is marked other than "natural", or flema 23 traumatic avent, the Med call and in the last Funeral 12. Was Decedant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, atc. 1 □ Naver Married 2 □ Married 1 ☐ Yas 2 No If Yes, Giva Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedant's Usuel Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working lifa. DO NOT use retired) Eigmantary/Secondary (0-12) Collage (1-4or 5+) Home maker 12+ In own home permit. Peges 1 end 2 should be file.
Department of Health and Mental Hyg.
Important: if Item 27 is marked other
any injury or other traumatic avent,
pages. 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fathar's Nema (First, Middle, Last) Edward A. Canoles Mary Alice Chester 19a. Informent's Name/Ralationship (Type, Print) daughter 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) 13558 Fork Rd., Baldwin, Md. 21013 Sharon Rohrbaugh 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cematery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 7/11/98 Baltimore, Md. Oaklawn 4 ☐ Donetion 5 ☐ Other (Specify) Cemeterv 22. Name end Address of Facility Joseph N. Zannino Jr., Funeral H 21. Signature of Funerel Service Licenses 263 S. Conkling St., Baltimore, Md. 21224 area 23e. Pert1. Emer the disaase, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximeta Interval Between Onset end Deeth **Physician** reposential infarction /Medical Immediate Cause (Finel diseese or condition resulting in daeth) Examiner Examiner Chisclerosi 7141 physician end the buriel-transit The law requires that the death certificate be executed Due to (or es e consequence of) Sequantially list conditions, if any, laading to Immadiate cause. Enter Underlying Ceuse (Disease or injury Records, P.O. Box 68760 Physician/Medical thet initieted events resulting in deeth) Lest Dua to (or as e consequence of) 186 0 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa coptribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown p 24b. Ware autopsy findings eveileble prior to completion of cause of death? should 24a. Wes an autopsy performed? Completed certificate has t director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital director, or Attanding Physician: 25. Wes case referred to medical axaminar?
1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) \$1572-R 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Manner of Deeth 28e. Deta of Injury (Month, Dev Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? After 1 Netural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accidant after death Director: / 6 ☐ Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Dis completely filled in Hospital 29a. Cartifian 1 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, dete end pleca, end due to the ceuse(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. one)
29b. Signature end title of attillion To the Vithin 2 29c. Ligense number 29d. Date signed (Month, Day, Year) (ann) 1

State Registrar

31. Data filed (Month, Day, Year)

MECITO M.

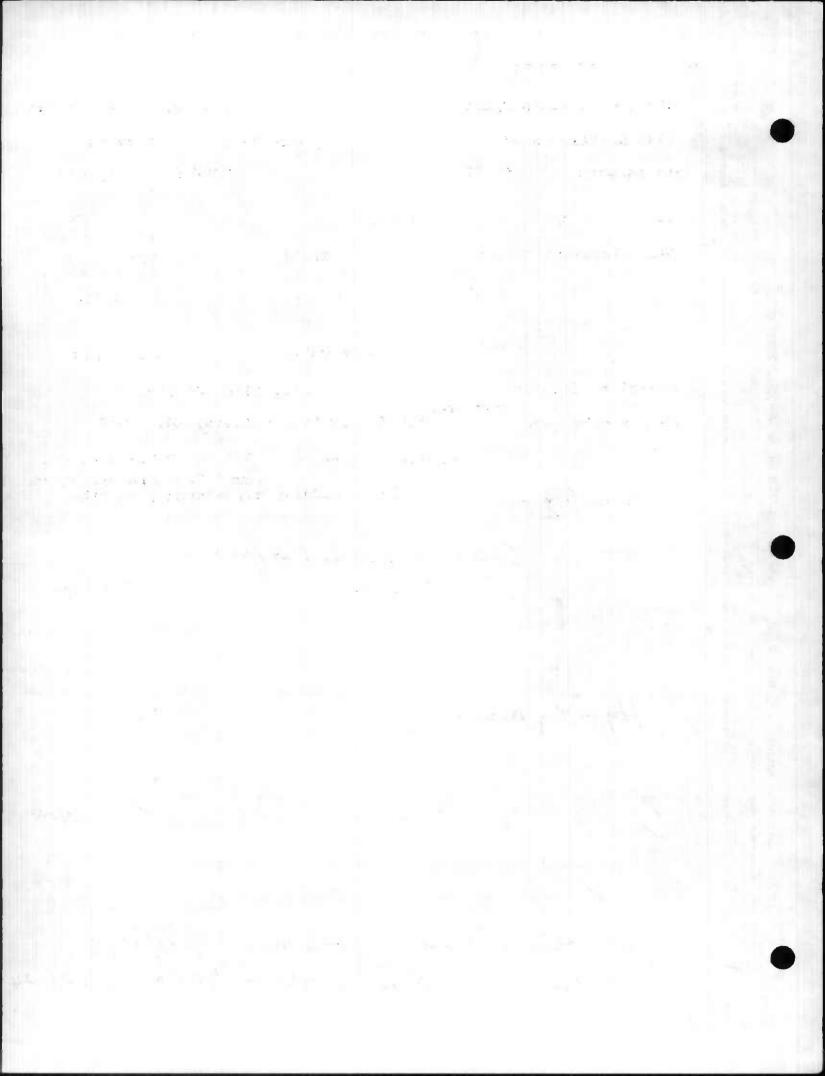
JUL 1 0 1998

30. Name and eddress of person who complated cause of daath (Itam 23a) (Type, Print)

32. Registrar's Signeture John Davidson Produce

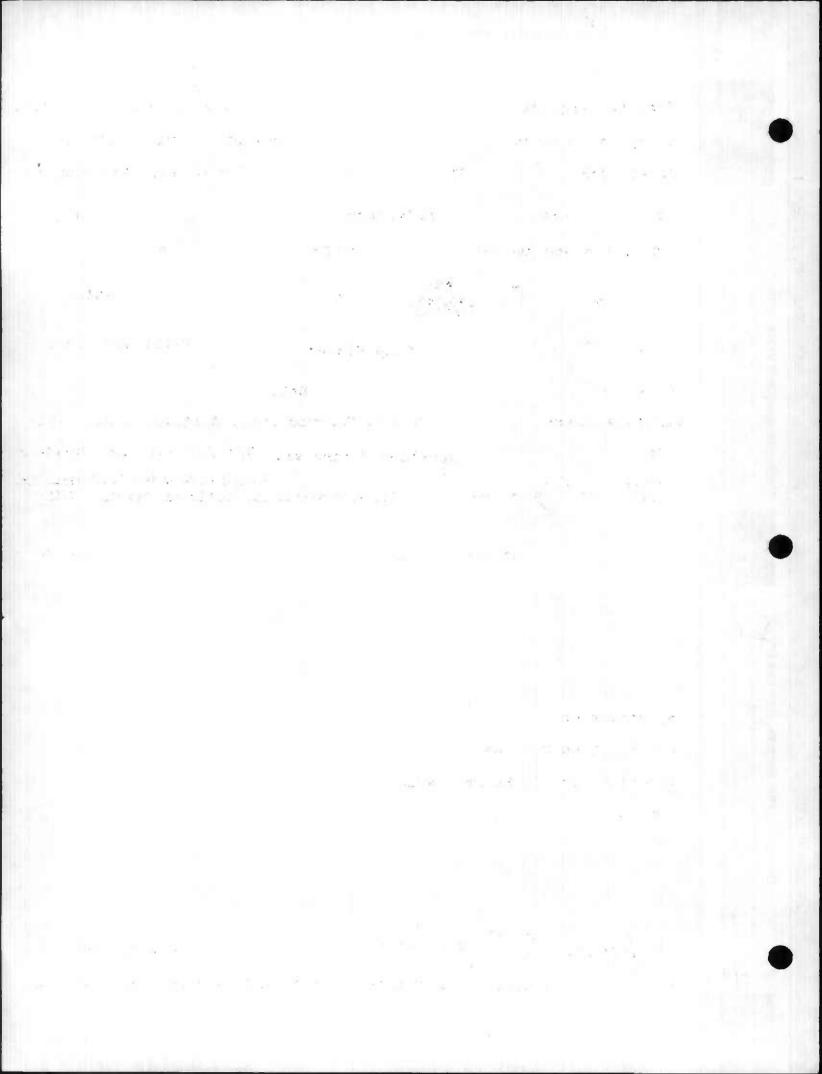
TORRES, MD

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 1 2 6 7

							(Certi	ificate of	Death			Reg. No.	No.	130.		
	2		1. Decedent's Na	ame (First, Middle, La	st)							2. Dete of De Month	ath Day	Year	3. Time of Deeth		
н	Physicia /Medic		Karl I	E. Silgra	adt								7, 199		8:20A.M.		
9	Examin	_	4a Facility Neme	(If not institution, giv	e street en	d number)				4b. City, To	wn, or Lo	ocation of Deet	dc. County	of Death			
A			VA MET	DICAL CEN	ITER					FT.	HOW	ARD	BALT	IMOR	E		
	Funeral		5. Sociel Security	y Number 6. 5	Sex		In yrs. last birtl	Judy/	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, De	th Year)	9. Birth	place (State or Foreign ntry)		
п	Director		022-09	9-2586	I 💢 M 2□	F 7	9 Y	rs.	violilis Days	riouis	197111.	OCT 6	1918	New	Hampshire		
	7		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location														
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	e Me	cto	MD	n/a	1		ват	CIM	ore						1 X Yes 2 No		
	15 P	Director	10e. Street and I		-				10f. Zip Code				10g. Citizen of	What Cou	ntry?		
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	fter dea	Funeral	11. Meritel Statu	s		Decedent Eve d Forces?	arin U,S. Army	13. We	es Decedent of H	Hispanic Or an, Mexice	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.))- 14. Rac Bla	ce - Ameri ck, White,	can Indian, , etc.		
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Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of	Funeral Service Lice	2	sanks in a									Funeral Hm.		
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а	/Medical Examiner	П	Immediate Caus disease or cond resulting in deat	ition	e. Me	tasta	tic C	anc	er					1	Month		
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	thin the	Mec		and title of certifier	and	manner stete	0.		29c. Licen	se number			29d. Dete sign	ed (Month	, Day, Year)		
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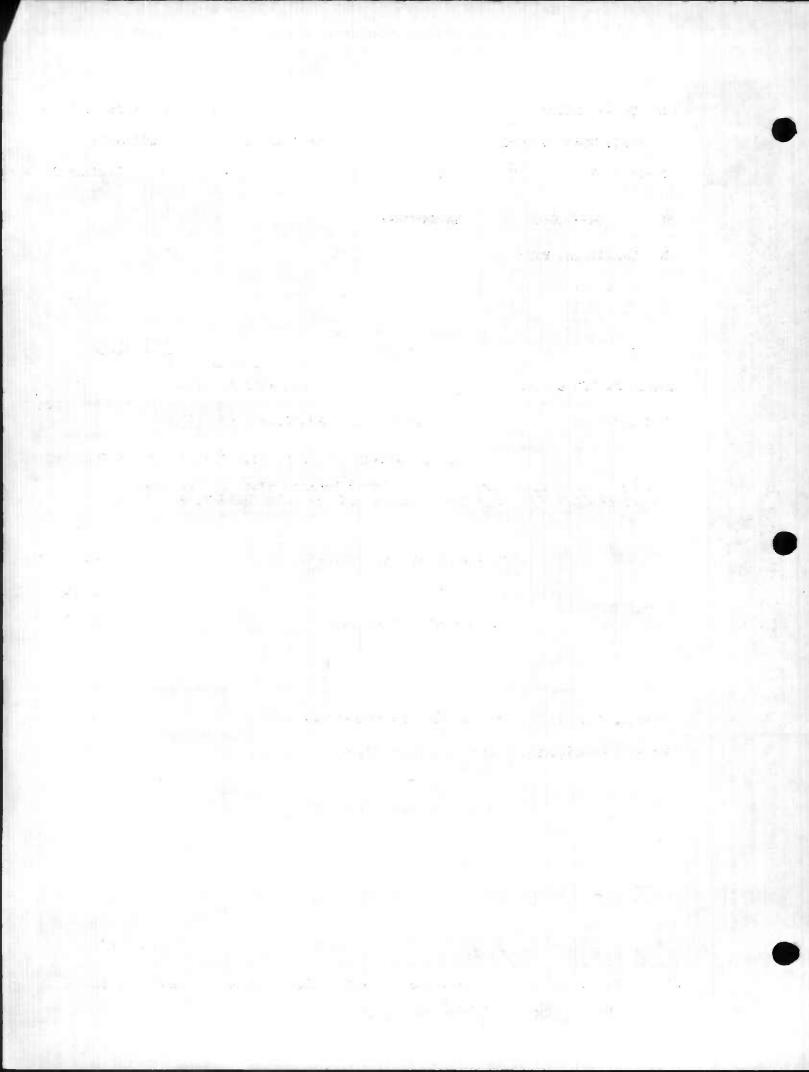


State of Maryland / Department of Health and Mental Hygiene 9

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				Certificat	te of	Death		F	leg. No.				
	1. Decedant's Nama (First, Middle	Last)					2	. Data of Dea	ith	Vaa-	3. Time of Death		
Physician	TDA SUSAN SIL	FR						JUNE	Day 29	Year 1998	1:00 AM		
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	20a. Method of Disposition	2 Damouel from Or	cemeten	Disposition (Na , crematory or	me of other pla	ce)		Data	20c. Location	- City or T	own, Stata		
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Othar (Sp			UTHERAN	CH.	CEM.	JULY	1.199	8 BAKE	ERSVI	LLE, MD		
1	4 Donation 5 Other (Specify) SALEM LUTHERAN CH. CEM. JULY 1, 1998 BAKERSVILLE, MD 21. Signature of Funerel Service Licensee BROWN FUNERAL HOME, 327 W. KING ST.,												
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	23a. Part1. Entar tha disaasa, or shock, or haart failure. List of	nly ona causa on aac	sad tha daath. Do n h iina.	ot antar tha mo	de ot dyli	ng, such as	cardiac or	raspiratory ar	rast,		Approximate interval Between		
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SICI	Part ii. Other significant condition	s contributing to deat	h but not rasuiting In	tha undariying	causa giv	ven in Part i		23b. Dld t	obacco use co	ontribute	to the cause of death?		
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tor	1 Nafural 5 Pending		Day Year) fr	jury M		rk? ∣Yes 2 🔲	No						
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	card,	newsy 4			'								
	30. Nama and address of person v	no completed ceusa o	of deeth (Item 23e) (Type, Print)									
	Dr. Edson Mod	dy, 1190	Mt. Ae	tna Ro	ad,	Hage	ersto	own, N	laryla	nd 2	1740		
	Of Date filed Manth Day Vess	20 Dec	later de Cianatana		100	-			-				

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 1998 11:00 AM Shirley Williams JULY 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Mariner Health of Glen Burnie Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Days | Hours | Min. | OC Month, Bay, Year | 1931 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country). Months 1 M 2 KF 66 Yrs. Maryland 219-28-4353 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Linthicum Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21090 319 School Lane USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: caucasion 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementery/Secondary (0-12) College (1-4or 5+) 12 Medical Assistant Medical 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Norman G. Reinhardt Anna Delmar Connelly 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Keith Williams - son 705 Wooddale Road, Linthicum, Md. 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 7/15/98 1 Burial 2 Cremation 3 Removal from State Elkridge, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Mem. Park 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP Laura Dexter 7250 Washington Blvd., Elkridge, Md. 21075 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximete Interval Between Onset end Death tEIMER I fmmediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events resulting to deeth) Lest Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably A Unknown CEREBROVARCHLAR ACCI 24b. Were autopsy findings eveitable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 3 No 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ EP/Outpetient 3 ☐ DOA 1 ☐ Yes Other: ■ Nursing Home 5 Residence 6 Other (Specify) 27. Manna De th 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

2 Q

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, me Magical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23, any injury or other traumetic event, the Medical Examinal manal

with the Maryland

certificate has

Physician/Medical Examiner

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Completed

Be

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Certification:

edicai

Division of Vital Records, P.O. Box Physician: within 24 hours after death. To the Funeral Director: After this funeral or Attending filled in by

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State Registrar

3 Suicide

(Check only one)

29a. Certifier

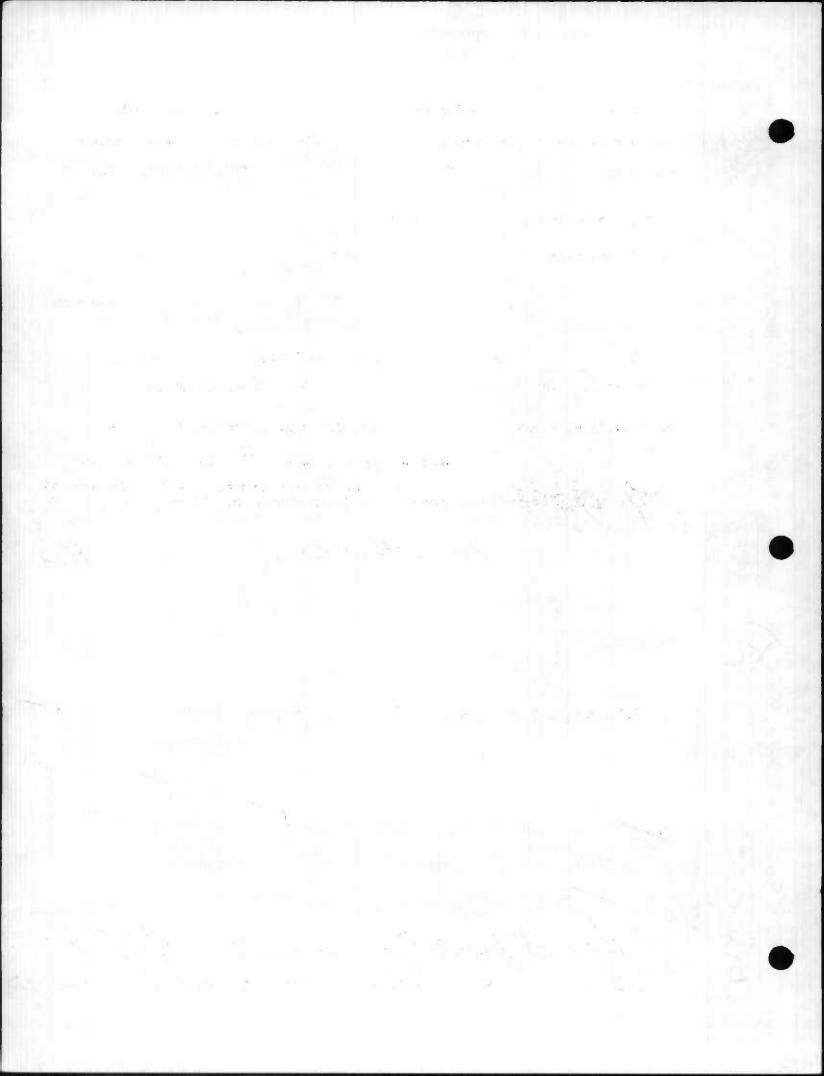
28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 5 ☐ Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and titly of certified 29d. Date signed (Month) Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Redistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** /Medicai 4b. City, Town, or Location of beath 4a. Facility Nama (If not institution, give street and humber) **Examiner** UA HOURS Min BAYVIEW JONNS HOP (IWS 6. Sax, 1 M 2 F 7. Aga (In yrs. last birthday) Yrs. If Undar 1 Yaar **Funeral** Days 215.01.3467 Usual Rasidance of Decadent Director OIA Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director 0 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 84 by Funeral 12. Was Dacedant Evar In U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritel Status 1 Navar Married 2 Marriad 1 Yas 2 No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Spacify only highast greda complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry (1-4or 5+) Elamantary/Secondary (0-12) OIN 17. Fathar's Nama (First, Middla, Last) Be UNKNOWN LATKOWSKI FRANCES Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) partment of Health a portant: If item 27 is HRIINGTOND 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 26c. Location - City or 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Department 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Sarvice Licensaa olicy 23a. Part1. Inter the disease, or complications that caused the death. Do not anter the mode of dying, shock, or haert failure. List only one cause on each ha. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final **Examiner** Physician/Medical Examiner and -transit Sequantially list conditions, if any, laading to Immadiata causa. Enter Underlying Cause (Diseasa or injury thet initiated avents rasulting in deeth) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68766 Dua to (or as a consequanca of): USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use centribute to the cause of death? 1 🗆 Yeş 2 No 3 Probably 4 Unknown seco Completed by 24b. Wara autopsy findings available prior to perplation of cause deeth? 24a. Was an autopsy performed? 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to predical axaminer?
1 ☐ Yas Hospital or Attanding Physician: Be 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) Certification: To 1 Inpatiant 2 ER/Outpetient 3□ DOA After this 28a. Deta of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred 5 Panding Invastigation 1 Natural s after death. 1 ☐ Yas 2 No 2 Accidant 6 Could not be 3 Sulcida Location (Straat and Number or Rurel Routa Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, deeth occurred et tha tima, data and place, and dua to tha causa(s) end mannar as stated. Medicai 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner stated. To the To the To the I 29b. Signatura and titla of cartifiar 29c. Licansa number Mis 100 me end eddress of person who completed cause of deeth (Item 23e) (Type, Print) PATRICIO

32. Registrar's Signatura

his Davidson

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Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Francis Woodrow July 7, We1ch 1998 10:35pm 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c, County of Death 1055 Harding Boulevard West River Anne Arundel If Under 24 Hrs 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Months Deys Hours XXM 2 F 577-26-2615 Yrs. May 3,1919 Maryland Usuel Residence of Decedent 10c. City, Town or Location West River 10d. inside City Limits Anne Arundel 1 ☐ Yes 2 No No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 1055 Harding Boulevard 20778 USA Race - American Indian, Black, Whita, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married White 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Waterman/Carpenter Carpentry 8 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Francis Guy Welch Marian Stinnett 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Kathryn Reginia Welch-Wife 1055 Harding Boulevard, West River, MD 20778 20b. Plece of Disposition (Name of cametery, cremetery or other p 20a. Method of Disposition Dete 20c. Location - City or Town, Steta 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory 7/9 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Eugeral Service Lice 22. Name and Address of Fecility Hardesty Funeral Home, P.A. 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediete Ceuse (Finet diseese or condition resulting in deeth) Due to (or as e consequence of): Due to (or as a consequenca of):

Physician /Medical Examiner

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Baltimore, Maryland 21215-0020

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Division of Vital Records,

Hospital within 24 hours of To the Funeral C

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Physician/Medical The law requires that the death by

Completed certificate or Attanding Physician: Be Certification: To this efter death. filled In by

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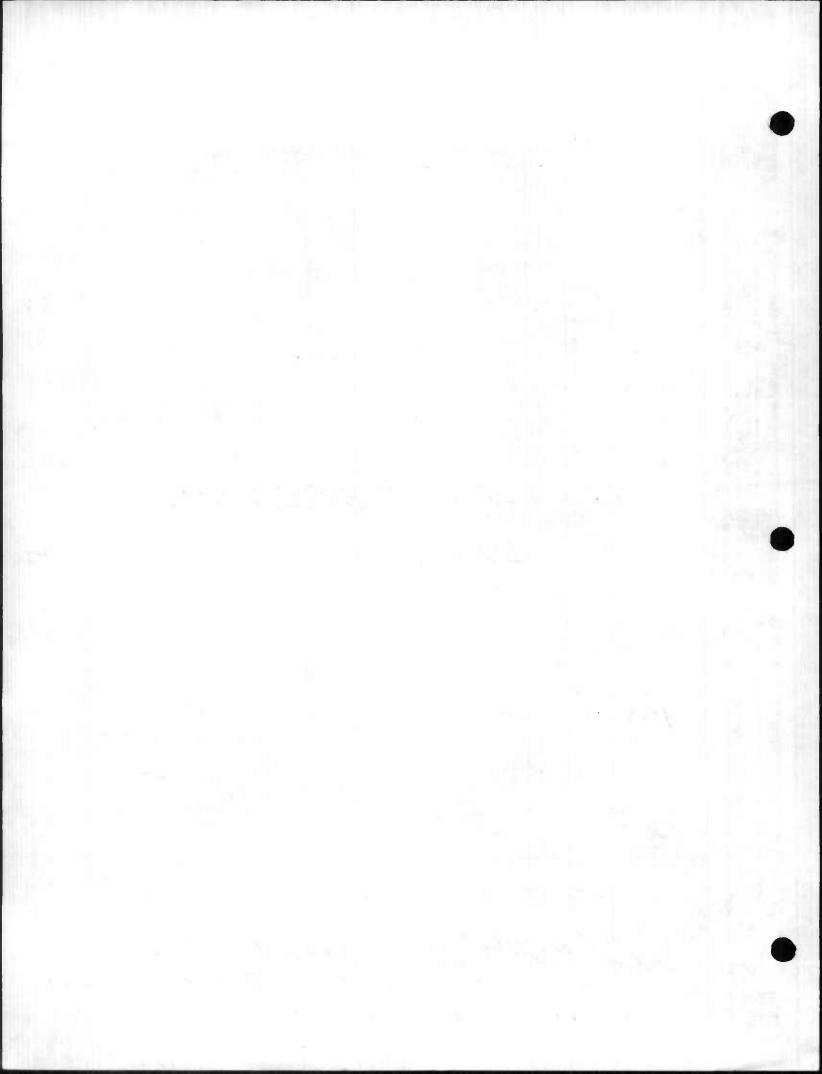
FRIBERUX MID 20670

State Registrar

completely

31. Date filed (Month, Dey, Year)

32. Registrer's Signeture Mia Davids



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death **Physician** Month JOHN G. WEIDINGER JR. 1998 12:57 P.M. July /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FRANKlin SquARE CenTer | BALTIMORE HospilA Ale ose 5. Social Security Numbar If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Birthplace (Stete or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) **Funeral** 1√2 M 2□ F Days Hours 219-18-9481 Director Maryland Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Md. Baltimore Essex 1 Yes 21 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? filed within 72 hours efter death with 205 Dorell Road 21221 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1√J Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lifa. DO NOT use retired) Elamantary/Secondary (0-12) Collage (1-4or 5+) Sr.Instrument Trchnician Eastern STainless 12th permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othe any lojury or other traumatic event 2015s. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meldan Surnama) Be John G. Weidinger Sr. Bessie Pearl Waudby 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Margaret Weidinger / wife 205 Dorell Road Baltimore MArvland 20b. Place of Disposition (Neme of cemetery, cremetory or other plece)
Moreland Memorial 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removal from State 7/10/98 Baltimore Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Connelly funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 23a. Part1. Enter the disease, or compositions that caused the death. Po not enter the mode of dying, such as cerdiac or raspiratory arrast, shock, or heart failure. List only a causa on each line. Approximate Interval Baty Onsat and Death **Physician** /Medical Immediate Cause (Final · PreumoniA disease or condition resulting in daath) 6 WEEKS Examiner Dua to (or as a consaquanca of): Examiner Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68769 by Physician/Medical or Attending Physician: The lew requires that the deeth certificate Due to (or as a consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Chronic ObsTructive Pulmonary 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed certificate 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Was casa raferred to medical 26. Placa of Death (Check only one) 1 ☐ Yes 2 No 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To After this 28a. Date of Injury (Month, Dey Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding deeth. 1 ☐ Yes 2 ☐ No 2□ Accident Investigation ofter deeth Director: / in by the 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide • Funeral Di Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. Medical Certifying Physician: To the dest of my knowledge, death occurred at the little, date and place, and due to the destact, and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Dete signed (Month, Dey, Year) 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) id

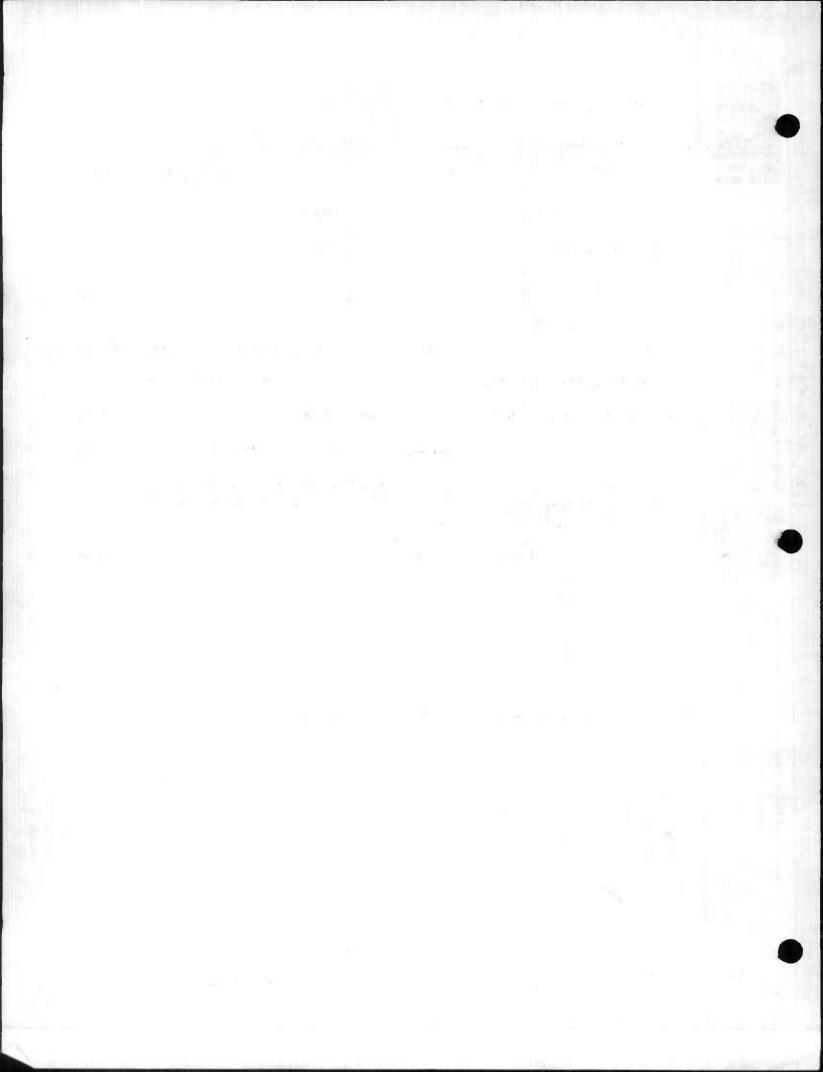
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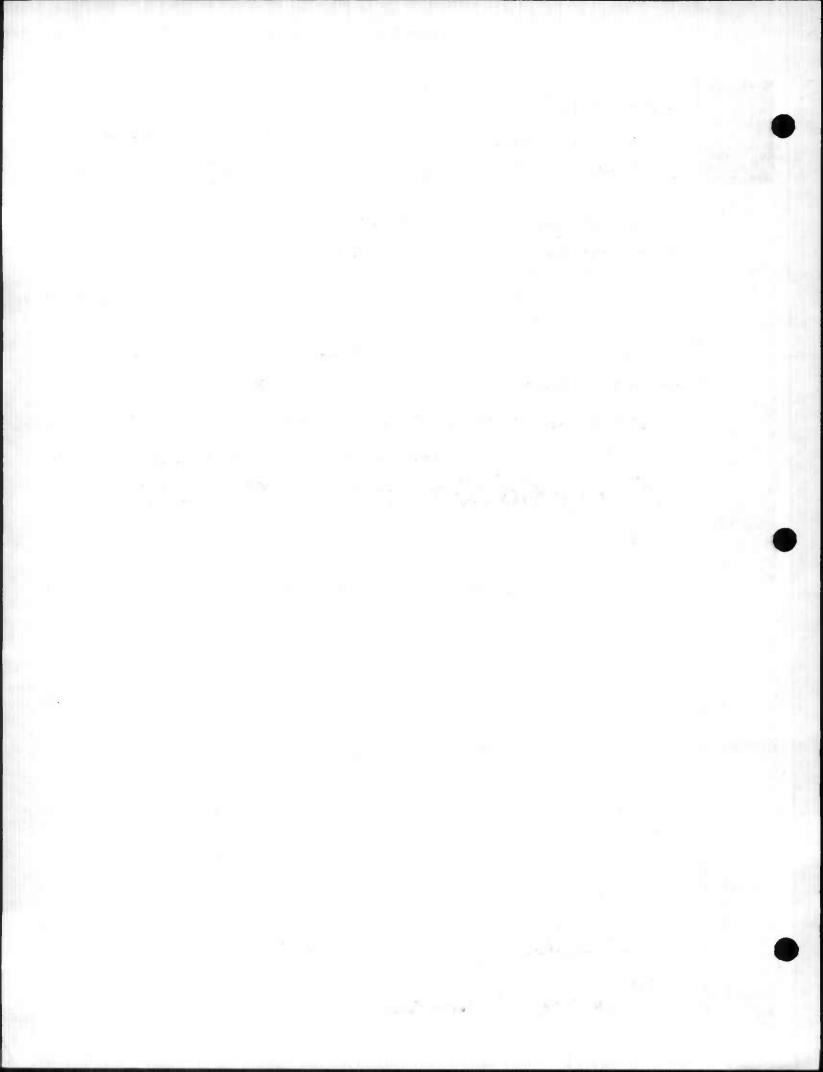


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2 Date of Death 3. Time of Death Month **Physician** JOANN ALBRIGHT JUNE /Medical 4e. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 53 East Main Street Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State (Month, Day, Year)) Dec. 20, 1942 Maryland 5. Social Sacurity Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2X F Yrs. Director 55 218-40-1050 Usual Residence of Decedant death with the Maryland r 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 □ No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? r than "natural", or items 23s or the Medical Examiner must be 53 East Main Street United States 21157 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, atc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental thygiene. ant: If Item 27 is marked other than "natural; or ite any or other traumatic event, the Medical Evantive. Yas 2 No f Yas, Giva 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Dacedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 81/2 Housewife Domestic 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be George Alfred Brown Roe Mae Bowers 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 53 E. Main Street, Westminster, MD 21157 George C. Albright, Sr/husband 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. Carroll Crematory 6/26 Hampstead, Maryland 21. Signature of Funeral Service Lice 22. Nama and Addrass of Facility Myers Funeral Home 91 Willis Street Westminster, MD 21157 23e. Part1. Enter the disease, or complications that cause the death on ot enter the mode of dylng, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical Immediate Cause (Final disaasa or condition rasulting in daath) Examiner Examiner ancer law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Causa (Disaasa or Injury that Initiated events rasulting In death) Last Dua to (or as a consequence of): Physician/Medicai Dua to (or as a consequence of): as USB been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Onknown 1 Yes 2 No þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy complation of causa of death? s certificate has l 1 Yas 2 No 1 ☐ Yes 2 No Hospital or Attanding Physician: '24 hours after death.'
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2 Medical Examinar: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifian Medicai 29b. Signatura and title of certifier 29d. Date signed (Month, Day, Year) 29c. Licansa numbar 30. Nama and addrass of person who complated cause ot death (Item 23a) (Type, Print) Alexander Rocha M.D. 4231 Northwoods Trail, Hampstead, MD

State Registrar

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760



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Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Date of Death 1 Decedent's Neme /First Middle Last **Physician** 7:30 AM MAIVI Tune 26, 1998 /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner #202 Anne Arundel 2016 Gov. Thomas Bladen Way Annapolis If Undar 1 Yaar If Undar 24 Hrs. Months Deys Hours Min. 8. Data of Birth OCT 1, 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** 1□ M 25 F Mar VI and 577 22 1431 77 Yrs. **Director** Usuel Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits with the Marylar r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Anne Arundel Annapolis Directo 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2016 Gov. Thomas Bladen Way #203 21401 United States Funeral death 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. hours after 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1□ Yes YNO Specify. White ď 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b Kind of Business/Industry Jennii. Pages 1 and 2 should be filed within 72 to Department of Health and Mental Hygiene. Inportant: If them 27 is marked other than "nati Elementery/Secondary (0-12) Collega (1-4or 5+) Department Store Sales Clerk If risath and Mental Hygin Nem 27 is marked other 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Edna Hardesty Leslie Norfolk 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) 21401 19a. informant's Name/Raletionship (Type, Print) 2016 Gov, Thomas Bladen Way # 202, Annapolis, MD Edna Jean Lauck (SISTER) 20b. Place of Disposition (Nama of camatary, crametory or othar placa) June 29, 1998 20a. Mathod of Disposition

20a. Mathod of Disposition

20a. Mathod of Disposition

3 □Ramoval from Stata 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signeture of Funaral Service Licansec 22. Nama and Addrass of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Entar tha disaasa, or complications that causad in daath. Do not antar tha mode of dying, such as cardiac or raspiretory arrast, shock, or heart failura. List only ona cause on aach line Approximata Interval Batween Onsat and Deeth **Physician** Mi Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician and for usa as the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laeding to immadieta causa. Entar Undarlying Cause (Disease or Injury that initieted avents rasulting in daath) Last Dua to (or as a consequence of) O. Box 68760 Dua to (or as a consaquanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 1 Yes 2 No 3 Probably 4 Unknown ۵ yd bengis Division of Vital Records, þ 24b. Wera autopsy findings evailable prior to 24a. Was an autopsy performed? Completed peen s completion of causa of death? page 2 s has 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: Be 25. Was casa rafarrad to medical 28. Placa of Death (Check only ona) To the Hosping.

within 24 hours after deeth.

To the Funeral Director: After this ce Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 1 Yes 2 No P L 1 Inpatient 2 ER/Outpatient 3 DOA Deta of Injury (Month, Dey Year) Certification: 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Plece of injury - At home, farm, street, factory, offica building, etc. (Spacify) 4 Homicide edical 29a. Cartifia 1 critifying Physician: To tha best of my knowledge, daeth occurred at the time, date end plece, end dua to tha cause(s) end manner as steted. 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. (Check only one) 29d. Data signad (Month, Day, Year) 29b. Signatura end titla of cartifian 29c. Licanse numbe 26

m 23a) (Type, Print)

32. Registrer's Signatura

Alin Davilson Randall

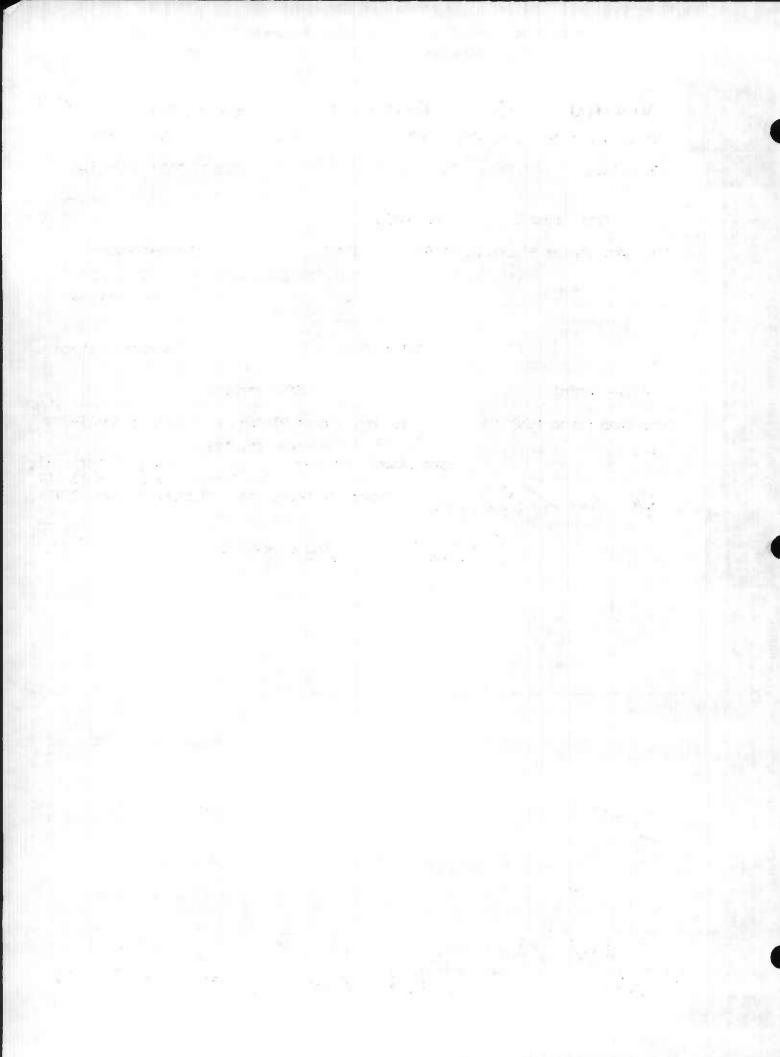
State Registrar and addrass of person

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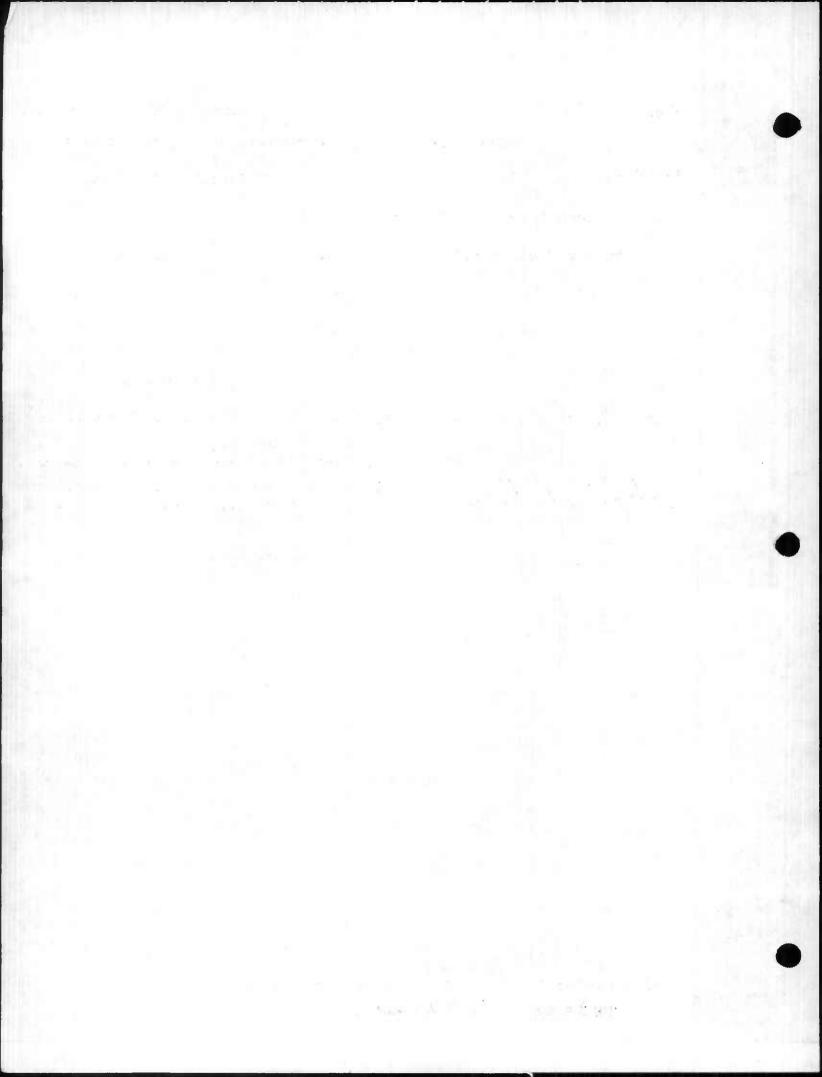
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1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_				State of Marylar		rtificate o			Reg. No. 98	100	1276
п	Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Yaar	3. Time of Death
Л	/Medi		Valerie Jean Boden						2, 1998		7:15 p.m.
ä	Examir	ner	4a. Facility Name (If not Institution, giva				4b. City, Town, or		, , , , , , , , ,		
L		_	118 Pleasant S 5. Social Security Number 6. Sec			If Undar 1 Yas	Centrev		Queen		
	Funeral Director			7. Aga (In yrs.	Yrs.	Months Day		(Month, De	7,1949		lace (Stata or Foreign try)
	dand tand		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10	0d. Inside City Limits
	Man,	to	Md. Queen A	nne's C	entre	ville					1 ☐ Yes 2 ☐ No
	h the	rec	10e. Street and Number			10f. Zip Code			10g. Citizan of V	Vhat Coun	try?
	th wit	ai D	118 Pleasant Sp	rings Driv	е	2	1617		U.S	.A.	
Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Modical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden! Evar in U Armad Forces? 1 ☐ Yas 2FNo If Yes, Give Year or Dates:		Was Decedani o If Yes, specify Cu 1 ☐ Yes ※XXN	Hispanic Origin? (Suban, Mexican, Puar o Specify:	Specify Yes or No to Rican, atc.)		e - Americo ok, White, o	etc.
2-0	72 ho	pet	15. Decedent's Educ (Specify only highest grede	cetion	16a. Dece	dent's Usual Occ	upation le during most of wo	dina	16b. Kind of Bu	usiness/Ind	lustry
21	ithin le.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	red)	rking			
7	ed wi	5	12	4	Но	memake				Self	
and	tal H d oth	Be	17. Fether's Name (First, Middle, Last) Robert Wilson					me (First, Middle			
2	1 Mer Merke netic	10						Virgin			21617
	end 2 st valth end 1 27 is n er traun		19a. Informant's Name/Relationship ($ au_{y_i}$ Daryl G. Boder		19b. Meilii 1	18 Plea	et end Number or R asant Sp	ural Route Numb rings	er, City or Town, Drive, (Steta, Zip Cent:	code) 21617 reville, M
Baltimore,	ont of ht: If it		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emovat from State	cemetery, crei	esition (Neme of metory or other p		e 24,1			wn, State
==	Departm Departm Importar any Injui		21. Signature of Funeral Service License								eral Home
m	Depa Impo any Ir		And on	Chipagni							
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	Physician	1	snock, or near future. List only on	e ceuse on each line						İ	Interval Between Onsat and Death
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н	Examiner		resulting in deeth)		or as e consec			417.0			[] []
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	it the death certificate be executed by the ettending physician and tached for use as the bunel-transit	Examiner	Sequentially list conditions,	Due to (d	or as a consec	quence of):					
68760,	be ey ician burie	aiE	Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or Injury								
387	phys the	edicai	that Initiated events resulting In death) Last	Due to (o	r as a conseq	uence of):					
-				•							
ğ	eath etten for u	ciar									
o.	y the	Physician/M	Part II. Other significant conditions con	tributing to death but not res	ulting In the u	nderlying ceuse (given In Pert I.				the cause of death?
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Division of Vital Records, P.O. Box	law requires that the death cer ias been signed by the ettendin a 2 should be detached for use	Completed b						24e. Wes	en eutopsy ermed?	ava	ere eutopsy findings ailable prior to appletion of ceuse death?
Ψ.	The ate h	E O						10	Yes 2 No	1□	Yes 2□ No
II a	ysician: The scartificate director, pag	Be (25. Was cese referred to medical examiner?				26. Plece of De	eth (Check only o	one)		
>	Physic this ce ral dire	To	1 Yes 2 No		ER/Outpatier	nt 3 DOA	ther: 4 \sum Nursing H	lome & Resi	dence 6 Oth	er (Specify)
_	fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Panding	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. In	ury at ork?	28d. Describe	how injury occur	ed	
Sio	eath. or: A the fu	cati	2 Accident Investigation				□Yes 2□No				
DIA	Il or Attending P elfer death. I Director: After ti d in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif		eet, factory, offic	9	28f. Location (City or To	Street end Numb vn, Stete)	er or Rurai	Route Numbar,
	Hospita 24 hours Funeral	edical C	29a. Certifier (Check only one) Certifying Physical Examination	clan: To the best of my kno er: On the basis of examina and menner stated.	wledge, death tion end/or Inv	occurred et the restigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	ceuse(s) and ma date and place,	nner as stand due to	ated. the cause(s)
	within To the comple	Z S	29b. Signatura and little of certifiar			29c. Lice	nse nu <i>m</i> ber		29d. Date signe	d (Month, L	Dey, Year)
	- s - ō			& Mbble	w	D	41587		1	23/0	
			30. Name and address of person who cor						010	- 11	[0
			Helen Noble; 1				town. Md	2162	0		
	Sta	-	31. Date filed (Month, Dey, Year)	32. Registrar's Slona	ture						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedant's Nama (First, Middle, Last) ESTHER C. 3. Time of Death DRAPER Day Month Vest **Physician** 9 July 01 1998 12:55 pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, giva street and number) Examiner Wicomico Nursing Home Salisbury Wicomico If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) 6. Sax 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□ M 3EJF 86 Director 217-01-8434 Sept.9,1911 Maryland Usual Rasidance of Decedant so filed within 72 hours efter death with the Maryland of Hygiene.

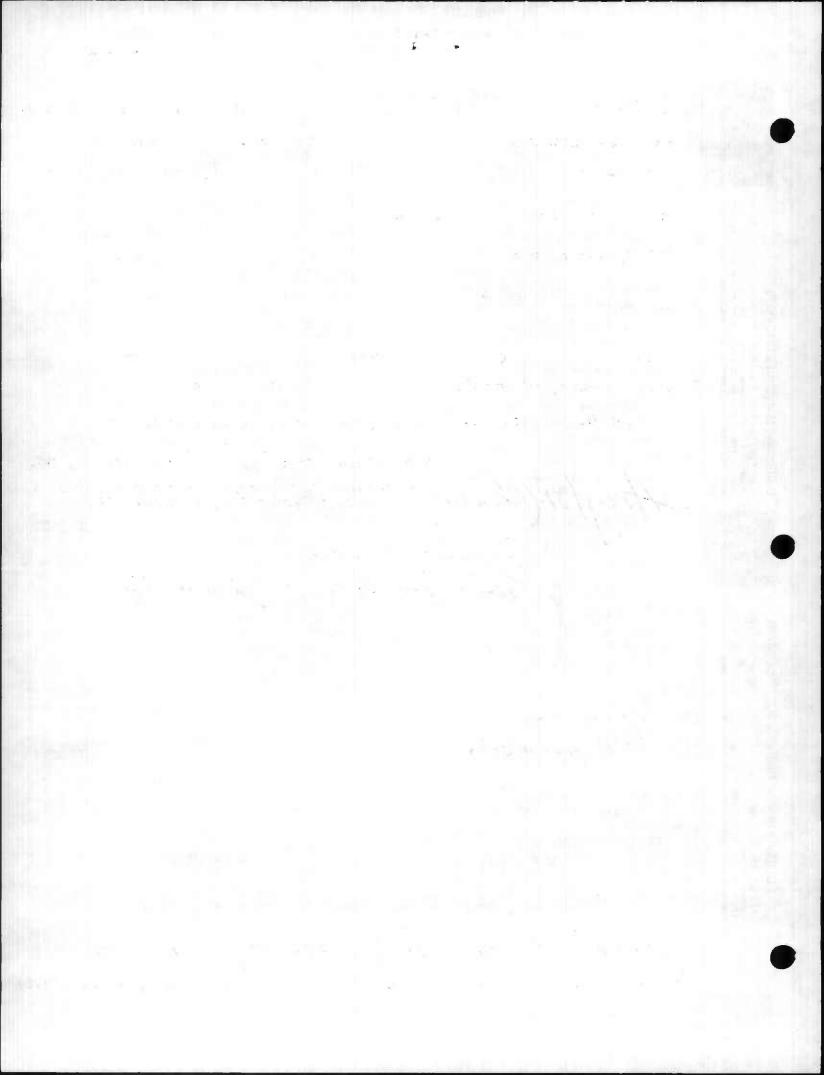
I Hygiene.

I Hygiene a Sa or 28a-f show with the Maryland structure from 23a or 28a-f show worth the Maddell Exeminer matter notified at 10d. Insida City Limits 10a. State 10c. City. Town or Location 10b. County Md. Wicomico Yas 2 No Salisbury Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 717 Spring Avenue 21804 U.S.A. Funeral 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puarto Ricen, atc.) 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: 14. Race - Amaricen Indian, Black, Whita, etc. 1 Navar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White p ₩idowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Eiamantary/Secondary (0-12) College (1-4or 5+) Homemaker Self 12 some. Pages 1 and 2 should be filled.
Department of health end Mentel Hyg important if hen 27 is marked other my injury or other traumatic event, 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumame) Maude Pullen Charles Henry Clayville 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. tnformant's Name/Raiationship (Type, Print) (Son) William O. Draper, Sr. 717 Spring Ave., Salisbury, Md. 21804 Baltimore, 20c. Location - City or Town, State 998 20b. Piaca of Disposition (Nama of cematary, cramatory or other placa) July 6, 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removel from State 4 Donation 5 Other (Spacify) Chesterfield Cemetery Centreville, Md. 22. Name and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville,
Do not enter the mode of dying, such as cardiac or raspiratory arrest, Approximate Interval Between Onset and Death Enter the **Physician** Immediata Causa (Final disease or condition rasulting in daath) /Medical Examiner Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to Immadiata ceusa. Enter Underlying Cause (Disease or injury that initiated avants Dua to (or as a consequence of) Box 68760 Physician/Medicai Dua to (or as a consequence of) rasulting in death) Last 80 ettending p for use es ed by the e 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed to Division of Vital Records. þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? Completed peen hes page 1 Yas 2 No certificete Physicisn: 25. Was cesa rafarrad to medical axaminar? Be 26. Placa of Death (Check only ona) 1 ☐ Yes 2 🛣 No Hospital: Othar: 4X Nursing Homa 5 Rasidance 8 Othar (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of funeral dir 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. tnjury at Work? 28d. Dascribe how Injury occurred 28b. Time of Certification: or Attending 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. Invastigation i Director: A 6 Could not be datarmined 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 3 Suicida To the Hospital or Att within 24 hours effer d To the Funeral Direct completely filled in by 4 Homicide 29a, Cartifiai 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. Licansa number 29b. Signature and title of certified 26 Reco Nama and addrass of person who complated ceusa of death (ttem 23a) (Type, Print) 5302 CHINABERRY DR., GALISBURY, MD 21801 M. BELLOSO, M.D .; GREGORIO 32. Registrar's Stgnatura 31. Date filed (Month, Day, Year)

Juna Wavidson-Randesse

State Registrar

JUL 0 6 1998



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		State of	Marylan		epartme <i>Certifica</i>				nental Hyg	giene Reg. No.	98	2/278
. Decedent's Nem								1	2. Dete of Dea	ath	Vanc	3. Time of Deeth
Edna	Grace	Ensor							July 5	5, Day	1998°	7:00 PM
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	alls Ro		44.		Willia.	- 1 Van		kton			altim	
. Social Security N 218-84-		6. Sex 1 □ M 2 🔀 F	7. Age (In yrs.) 8.5		frs. If Und	der 1 Yeer ns Deys		r 24 Hrs. Min.	8. Dete of Birth (Month, Day Sept. 8	y, Year)	9. Bir	thplece (State or Foreig
Jsuei Residence o			00		15.				Sept. 0	, 171	LZ Ma	ryland
Oe. Stete	10b. County			y, Town	or Location							10d. inside City Limits
MD	F	Baltimor	:е	Parl	kton							1 □ Yes 2 No
0e. Street end Nu						Zip Code					en of Whet Co	ountry?
	Falls F					2112				U.S.		
1. Meritei Stetus 1 ☐ Never Merr 3 🖫 Widowed		Armed For 1 Yes If Yes, Give Yeer or De	/0		1□ Yes	2 💆 No	Specify:		ecify Yes or No- Rican, etc.)	Sp	Bleck, Whit pecify: V	White
(Spec		s Education t grade completed) College (1-	1-4or 5+)	9	Decedent's Us (Give kind of w life. DO NOT arm Wi	work done Tuse retire	petion i during most ed)	it of worki	ing		of Business	/Industry
7. Father's Neme	/First. Middle, L	acti		L	JIIII W	TTE	18. Mothr	or's Name	e (First, Middle,		rming	
	rd Trac								Patte			
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9e. Certifier (Check only one)	2 Medicat Ex	Physician: To the base end menne	asis of exeminet	wledge, o tion end/	/or investigetio	on, in my o	opinion, deat	d piece, e	red et the time, d	dete and ple	lece, and due	e to the cause(s)
SprSignature and	d title of certifier	1/4.	-	A	1 +	9c. Licens	ise number	~ ~	7	29d. Uane s	signed (Moet	1 105

permit. Pagas 1 and 2 should be filled within 72 hours after death with the Maryland Debartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0020 **Physician** /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

Director

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Completed

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2

Physician/Medical Examiner 8 USB Completed by

To the Hospital or Attending Physician: The law requires that the death centrons within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending anysis. ata has been signed by the atterpage 2 should be detached for completely filled in by the funeral director,

Be 2

Certification:

Medicai

Division of Vital Records, P.O. Box 68766

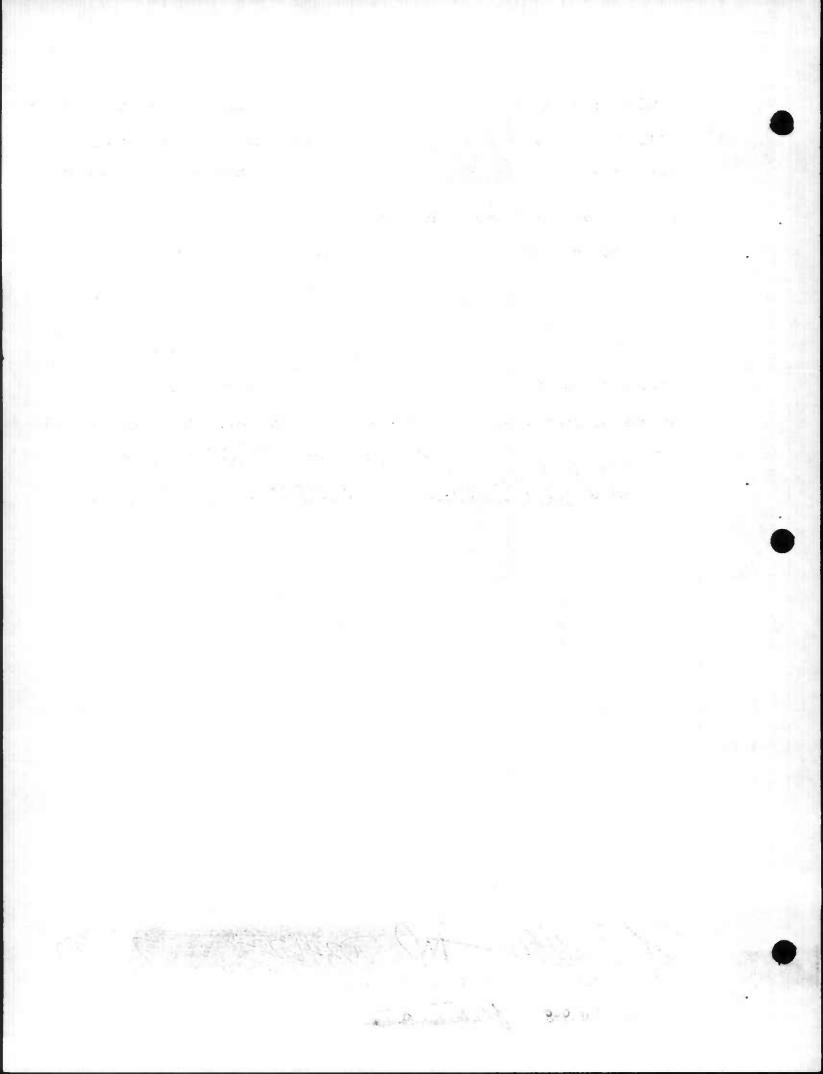
State Registrar

31. Dete filed (Month, Dey, Year)
JUL 1 0 1998

16940 York Road, Monkton, MD 21111

Dete filed (Month, Dey, Year)

132. Registrada Size hie Davidson-Pands



State of Maryland / Department of Health and Mental Hygiene 98

Dooth	
Death	Rea No

29d. Dete signed (Month, Dey, Year)

3326/

WILLIAM GODY, MD

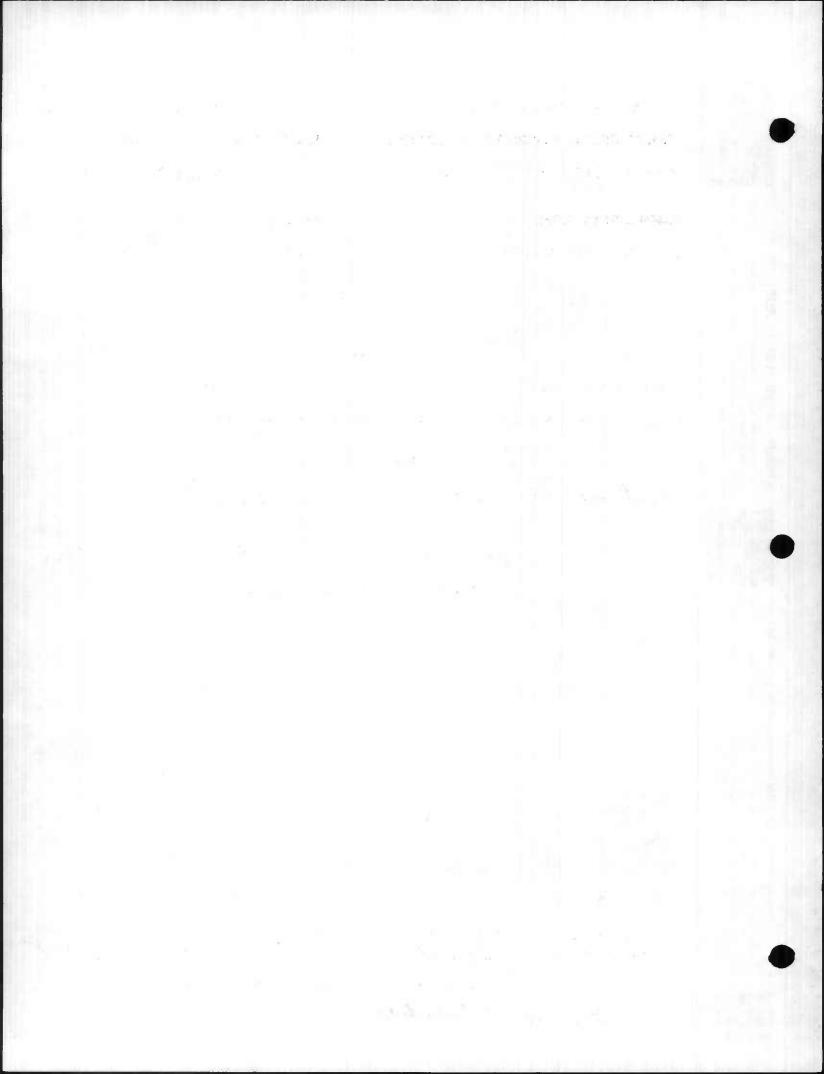
SHADY GROVE ADVENTIST HOSPITAL, ROCKVILLE, MARYLAND 20850

				Certificate of	Dealli	Re	g. No.			
	1. Decedant's Nama (First, Middle	, Last)			2. Data of Death Month	Day	Yaar	3. Time of Deeth		
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/Medical Examiner	4a Facility Nama (If not institution	, give street end number	ar)		4b. City, Town, or	Location of Death	4c. County			
LXC!!!!!!c!	SHADY GROVE	ADVENTIST	HOSPITA	AL	ROCKVIL	LE	MONTO	OME	RY	
Funeral	5. Social Security Number	6. Sex 7.	Aga (In yrs. lest birth	day) If Under 1 Yea			Vacal	9. Birthpl	ace (State or Foreign	
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rms 23a or 28a-f show rmust be notified at neral Director	Usual Rasidence of Dacedant									
show stat	10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Limits	
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or 28	10e. Street and Number			10f. Zip Coda		10	g. Citizen of V		try?	
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r items 23s or 28s-f solver must be notified from must be notified Funeral Director	11. Marital Status	12. Was Deceder Armed Force	s? NATO NITATIVE	13. Was Decedant of	Hispanic Origin? (5 ban, Maxicen, Puer	Specify Yas or No- to Rican, atc.)		- America		
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marked of imatic eve	HENRY RAYMOND	FENKER				A R. FOOT				
E an	19a. Informant's Name/Ralations			Mailing Addrass (Stre					Code)	
n 27	CAROLE ANN FENK	ER, WIFE		ST BARTHO	DLOMEW RD					
or other tr	20a. Mathod of Disposition 1 ☐ Burlal 2 ☎ Cremation	3 □Removal from Sta	cemetery	Disposition (Neme of cremetory or other p	lece)	Data 2	Oc. Location -	City or To	wn, Stata	
ury o	4 □ Donation 5 □ Othar (S)		CARRO	OLL CREMAT	IONS	6/27	HAMPS!	EAD,	MD	
Department of Heal Important: If item 2 any injury or other once.	21. Signelure of Funeral Service	icensee		22. Nama and Add	rass of Facility	ELINE FUN	ERAT. HO	MF.		
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32. Begistrer's Signeture
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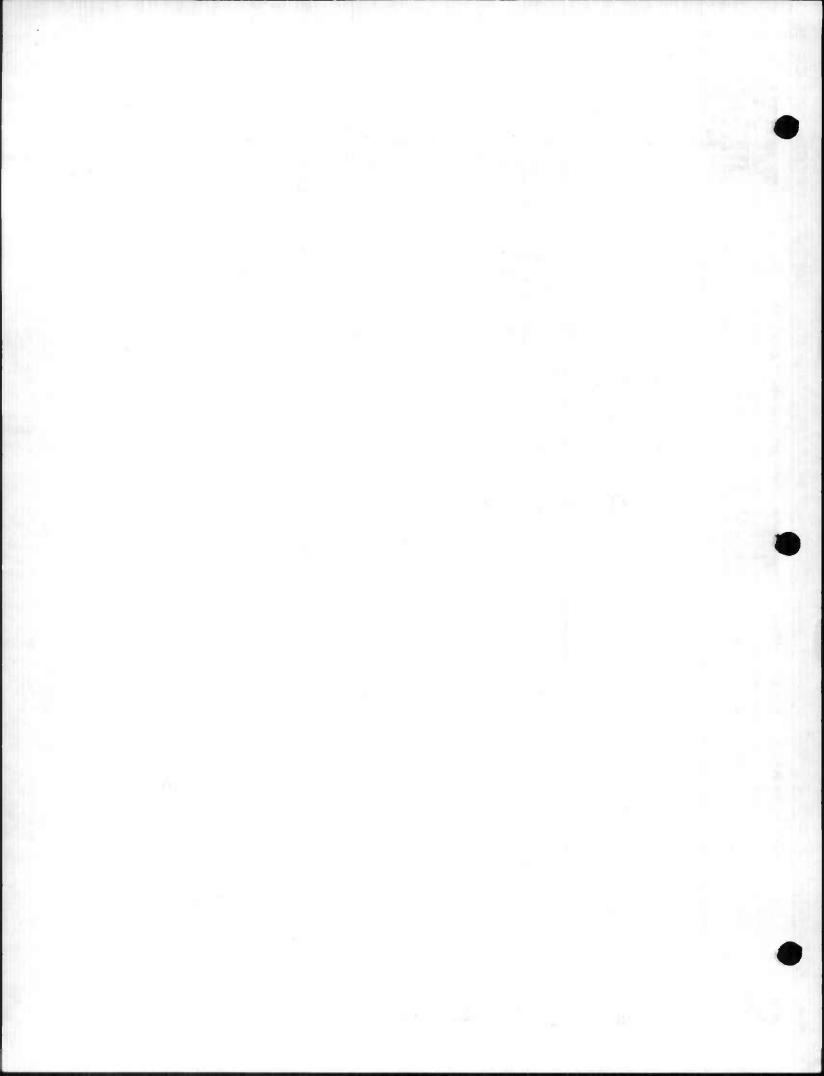
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State of Maryland / Department of Health and Mental Hygiene

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	and		Usuel Residenca of Decedent 10e. State 10b. County	10c, Cit	y, Town or Lo	ocation				10d. Inside City Limits
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	or 28s	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Whet Country?
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020	filed within 72 hours after death with the Maryland Hygiene. Ther than "natural", or ferma 23a or 28a-f show ent, the Medical Examinat must be notified at	by F	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	☐ Yes 2 2 No Yes, Give eer or Detes:		1 ☐ Yes 2 🗷 No	Specify:		Specify	White
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Ē	Pages ment of h tant: If ite jury or of		4 □ Donetion 5 □ Other (Specify)	Mou		View Ceme				ridge, MD
Bal	permit. Pages 1 and Department of Health Important: if item 27 any injury or other to 90.00.		21. Signature of Funeral Service Licanse	Wartle	11.7	2. Name end Addre E. Broad			Funeral dge, MD	
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	the death cert y the attendin ached for use	Physician/N	Pert tt. Other eignificant conditione contribut	ng to death but not res	ulting In the u	inderlying cause giv	ven in Pert I.	23b. Dfd	tobacco uee cor	ntribute to the cause of death?
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th complately filled in by the funeral	edicai	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer Caraminer C	To the best of my known the basis of exeminal menner steted.	wledge, deetl tion end/or In	h occurred et the tir vestigation, in my o	me, dete end plece pinion, deeth occu	, end due to the rred et the time,	ceuse(s) end me date end placa,	nner es steted. and due to the cause(s)
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			30. Name and address of person who completed PANSURIYA, MI	ed ceuse of deeth (Item	23e) (Type,	Print)	TRR-T	Han	DOTTA	D, MD 21074
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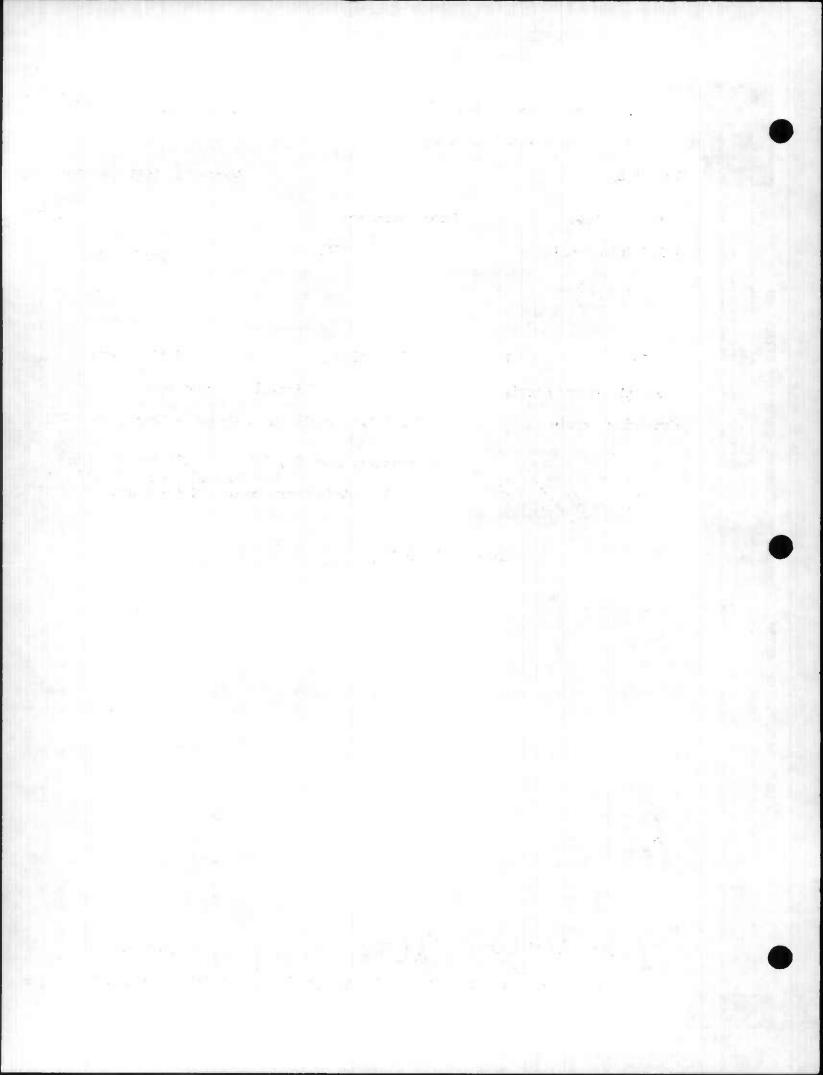


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Daath 3 Time of Death 1. Decedant's Nama (First, Middla, Last) Month 04:25 AM **Physician** HARRIS ATRICK JUNE 26 /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner UPPER TWIN WAY PRINCE GEORGES MARLBORO KNOLL 10517 If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 1□ M 2□ F Vre March 16, 1951 New York State Director 108 38 2952 Usuai Pasidance of Dacedani death with the Meryland 10c. City, Town or Location 10d. Insida City Limits 10a. Stata 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2000 Upper Marlboro MD P.G. Director 10g. Citizan of What Country? 10a. Street and Number 10f. Zip Coda 10517 Twin Knoll Way 20772 United States Funeral Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarlcan Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status of filed within 72 hours efter If Hygiene. other than "natural", or ite 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 □ Yas 2 700 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilega (1-4or 5+) Self Employed 12 Self Employed 18. Mothar's Nama (First, Middle, Maldan Sumama) 17. Fathar's Nama (First, Middla, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if fem 27 is marked oth any linjury or other traumatic event page. Virginia M. Armstrong Joseph Robert Harris 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 10517 Twin Knoll Way , Upper Marlboro, MD 20772 Katherine Harris 20a. Mathod of Disposition

1 Burial 2 Cramation 3 Ramoval from State 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, State 4 Donation 5 Othar (Specify) Lee Crematory June 26, 1998 Clinton, Maryland 22. Nama and Addrass of Facility ee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part 1. Ent if it a disaasa, if complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or it and failure. List only one cause on each line. Onsat and Daath Physician Immediata Causa (Final disaasa or condition rasulting In daath) /Medical CANCER LUNG **Examiner** Dua to (or as a consequence of). Examiner The law requires that the deeth certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in death) Last g physician end as the burial-tran Dua to (or as a consequanca of): Box 68760 Physician/Medical Dua to (or as a consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 94 signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Was an autopsy performed? Completed 24b. Wara autopsy findings available prior to Deen completion of causa of daeth? has page 1 Yas 2 No 1 ☐ Yas 2 ☐ No this certificate Division of Vital Hospital or Attending Physician: director, Be 25. Was casa rafarrad to madical 26. Placa of Death (Check only ona) axaminar? Hospital: Othar: 4 Nursing Homa 5 Assidance 6 Othar (Specify) 2 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mangar of Death 26d. Dascribe how injury occurred Certification: 28c. Injury at Work? After 1 Naturai 5 Panding invastigation 1 Yas 2 No deeth. 2 Accidant Director: / 3 Suicida 6 Could not be datarmined 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Homicida n 24 hour. the Funeral Directory edical 29a. Certifian 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the within 2 29d. Data signed (Month, Day, Year) 29b. Signature and title of 29c. Licansa number DME JUNE 26, 1998 ed causa of daath/(Item/23a) (Type, Print) 30. Nime and addrass of person who comp 3001 HOSPITAL CHEVERLY MARYLAND 20785 DRIVE MARIS GOLLIEN 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JUL 01 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth Month Day John Franklin Heddinger, Jr. **Physician** 16:56 1,1998 July /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) If Under 1 Yaar | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days XXM 2DF 217-16-7695 73 April 11,1925 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f ehow 10a. Stete 1 ☐ Yas X No Oueen Anne's Stevensville Md. Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ms 23a or U.S.A. 21666 216 Long Point Road Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Bleck, White, etc. r than "naturel", or items. 12. Was Decedent Ever in U,S. Armed Forces? 1€EVes 2 □ No If Yes, Give Peges 1 and 2 should be filed within 72 hours after to and of Health and Mental Hygiene.
Int: If Item 27 is marked other than "naturel", or item into or other traumatic event, its Medical Experientry or other traumatic event, its Medical Experientry. 1 ☐ Never Marriad 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 XXX Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced WWII Yeer or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Baltimore City Policeman 12 16. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Ethel Plummer John F. Heddinger, Sr. 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Mrs. Betty Heddinger (Wife) 216 Long Point Rd., Stevensville, Md. 21666 July 4, 1998 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition *Burial 2 Cremetion 3 Removal from Stata permit. Pege Department of Important: If eny Injury or once. Stevensville, Md. Stevensville Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Servica Licansee 22. Nema and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Rd., Chester, Md. 21619 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. **Physician** M1/0 cardia /Medicai Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed physician and s the buriel-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequenca of) for use as signed by the e Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes þ 24b. Were autopsy tindings avelleble prior to complation of causa of death? 24e. Wes an autopsy Completed s certificate has b director, page 2 s 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Wes case reterred to medical exeminer? Be 26. Piece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatiant 27. Menner of Death 28c. Injury et Work? 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2□ Accidant Investigation 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner es steted.
2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) 29b. Signature an Office of certifies 29c. License number 29d. Data signed (Month, Day, Year)

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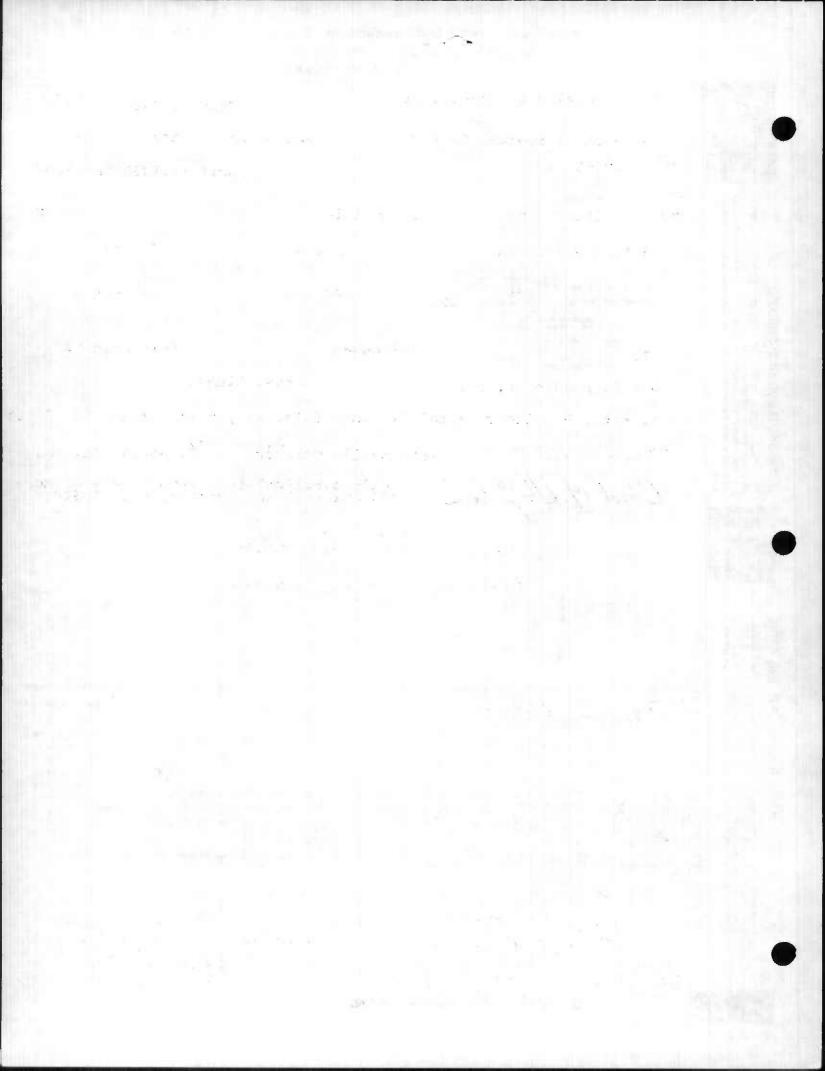
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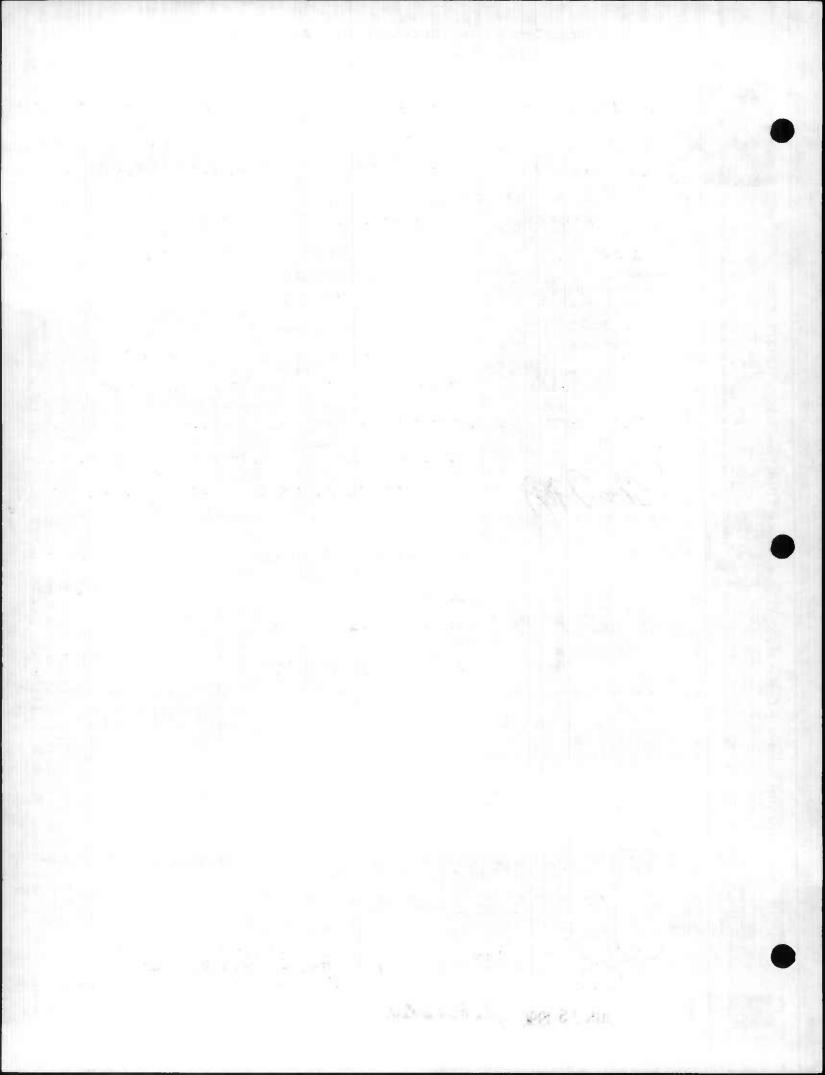
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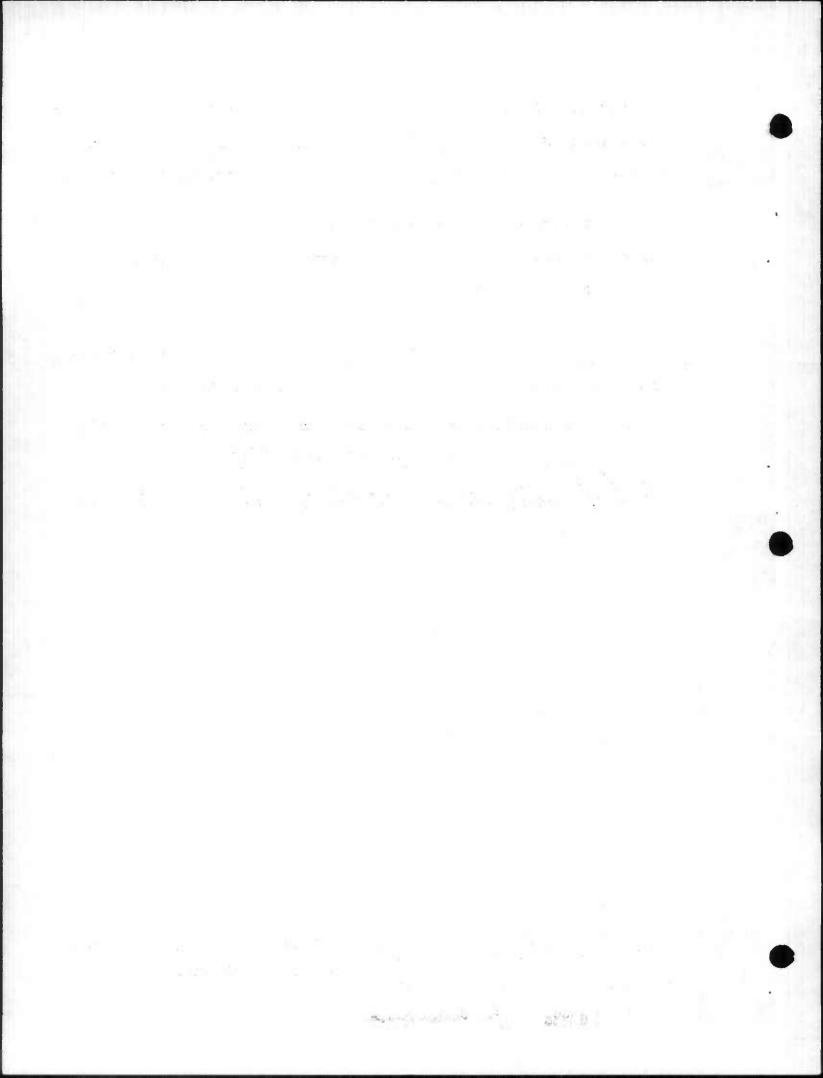
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State Registrar



				State of N	/larylar				lealth and I <i>Death</i>	•	giene Beg. No.	8 2	1284
	Physic /Medi		1. Decedent's Name (First, Middle, La. Betty Sue M	*						2. Dete of De Month July	oth Day 19	Yeer 98	3. Time of Death 9:00 AM
	Exami		4a. Facility Name (If not institution, given 21514 York Ro		r)				4b. City, Town, or I	ocation of Deet	4c. County	of Death	
	Funeral Director		5. Social Security Number 6. S 215-34-1941		nge (in yrs. 62	last birthday) Yrs.	If Under Months		Maryland If Under 24 Hrs. Hours Min.		Bali b, Year) 0, 1936	9. Birthpla Gountry Viro	
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	3a or 28	Il Director	10e. Street and Number 21514 York Ro	ad			10f. Zip		5		10g. Citizen of V		y?
020	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-f show may highly or other traumatic event, the Medical Examiner must be notified at DBCs.	by Funeral	11. Meritel Status 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced	12. Wes Deceder Armed Forces 1 Yes 2 If Yes, Give Yeer or Dates	? No			ent of H	ispanic Origin? (S on, Mexican, Puert Specify:	pectfy Yes or No o Rican, etc.)	- 14. Rec	ce - American ck, White, et	
21215-0020	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", raumatic event, the Meulcal Exa	Completed	15. Decadent's Ed (Specify only highest gra Elementary/Secondary (0-12)		r 5+)		ent's Usua dind of wor O NOT us ceta:		etion during most of wor d)	king	16b. Kind of B		
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	and 2 shousaith and N n 27 is man		19a. Informent's Neme/Reletionship (1) Joseph F. Mesza		oan d				end Number or Au Rd., Ma				
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 i any injury or other tra once.		20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (\$5000)	Removal from Stet		Place of Dispose complete, crem rktowne	ltion (Nen atory or or Cask Ser	ne of ther piece ets Vice	Inc. Ju	ly 9,	20c. Location - York,	City or Tow	
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State of Maryland / Department of Health and Mental Hygiene

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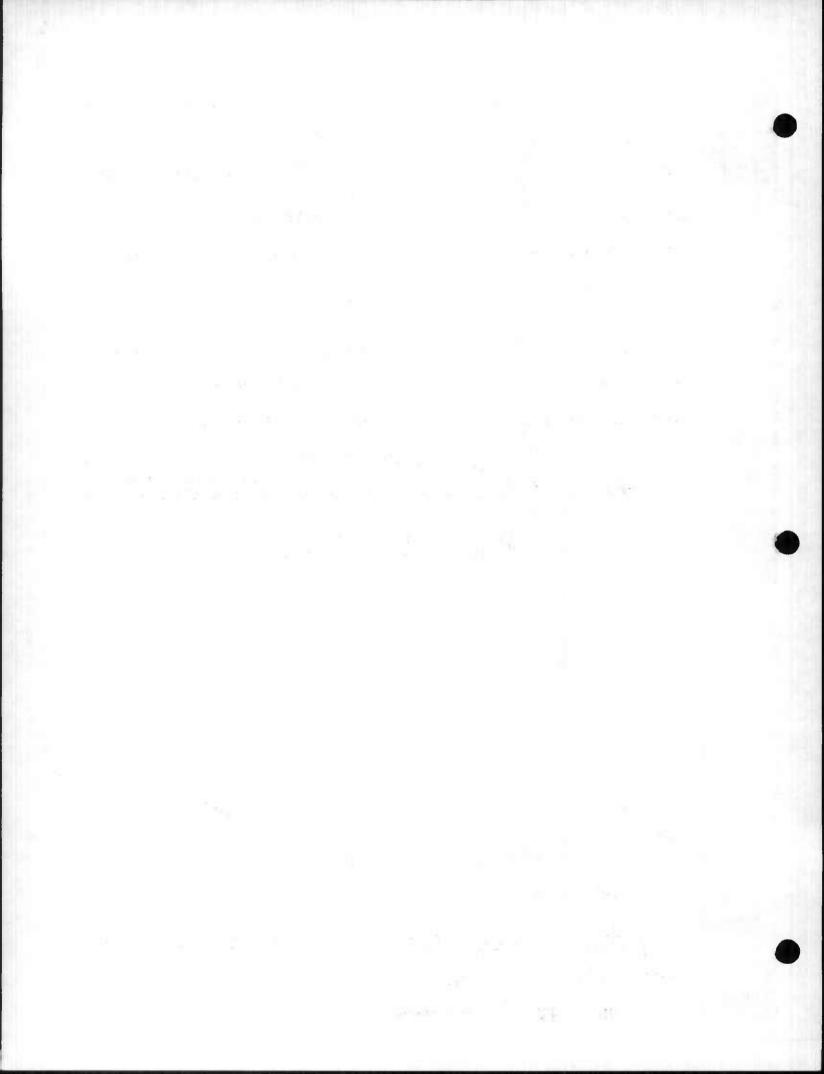
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			1. Decedent's Name (First, Mide	dle, Last)								2. Date of Dea		Vee	3. Time o	of Death
	Physic /Medi		MARY FRAN	CIS	McNE	ELLY						Month JUNE	20, 19	Year 98	9:10	ng 0
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L			4315 NEWPORT 5. Social Security Number	AVEN 6. Sex		7 Ago (In ura	ant historia d	If Under	1 Vaa	BALTIM			L	0 P: 11		
	Funeral Director		220-16-1198		M 2⊠F	7. Age (In yrs. I	Yrs.	Months	Days		Min.	8. Date of Birt (Month, Da) JUL 11	y, Year)		place (State of the state)	or Foreig
	and w		Usual Residence of Decedent 10a. State 10b. Count	v		10c. City	, Town or Lo	cation						1	0d. Inside C	City Limite
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2-0	2 ho	ted	15. Decade	nt's Educ	cation		16e. Decedent's Usual Occupation (Give kind of work done during most of work)						16b. Kind of E	Business/Inc	dustry	
Maryland 21215-0020	within 7 ene. than "n	Completed	(Specify only high Elementary/Secondery (0-12) 12			(1-4or 5+)	life. L	HOUSE	e retir	ed)	of Worki	ng	OWN HOME			
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			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complic	cations that	caused the death									Approxima	
).	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	a a	P	ancre	-	C		i Unce					Intervel Be Onset and	
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Betsy A. Fay, M.D.

State Registrar

31. Dete filed (Month, Dey, Year) JUN 2 4 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 10d, per F.H. 6/24/98, Carroll County, wj1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE **Physician** 28 1 ROBERT GILMORE STOUCH /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F Director April 16, 1908 Maryland 214-05-8091 Usual Residence of Decedent the Marylend 10d. Inside City Limits 10c. City. Town or Location r 28a-f show 10a State 10b. County 1 Yes 25 No Directo Maryland Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 end 2 should be filed within 72 hours efter deeth with Inen of Heelth end Mental Hygiene. Int: If fem 27 is marked other than "natural", or feams 23a or ? "natural", or items 23s or 21158 United States 205 St. Mark Way Apt. 406 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. P 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White WWII ir than "netur Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) Coilege (1-4or 5+) Machinery 11 Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 7 is marked traumatic ev Carroll King Stouch Estella Laura Haines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 205 St. Mark Way Apt. 406, Westminster, MD 21158 M. Verona Stouch, wife item 2 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date Important: If it sny injury or conce. tide Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/25 permit. Page Department of St. John Catholic Cemetery Westminster, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers Funeral Home 91 Willis Street Westm.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Westminster, MD 21157 **Physician** a. CHAONIC CYMPHOCYPIC CLUCKMIA

Due to (or as a consequence of):

Due to (or as a consequence of):

PRUMOWIA

C. PRUMOWIA /Medical immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examine physician end the buriel-transit lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical examiner? Hospital or Attending Physician: Be 26. Piace of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: / 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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24 hours at Funerat D etely filled i

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4 Homleide

(Check only one)

29e. Certifier

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date end piace, end due to the cause(s) end manner stated.

ALLOW COWY

29d. Date signed (Month, Day, Year)

Memorial Ave, Westminster, MD

Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 1998 June Hugh Albert Sweadner 1:24AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick 5. Social Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. lest birthdey) 8. Date of Birth Month, Day, Year) June 28, 1924 9. Birthplaca (Stata or Foreign **Funeral** 1 M 2 □ F Months Days Hours Maryland 219-14-8196 73 Director Usual Residence of Decedent the Merylend 10a State 10b. County 10c. City. Town or Location show 10d. Inside City Limits r than "natural", or items 23a or 28s-1 show Director Maryland Frederick Frederick 1 ☐ Yes 2 ☒ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9933 Woodsboro Rd. 21701 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other treumatic event, the Medical Exercised ORGE. Black, White, etc. 1 Tyes 2 No
If Yes, Give
Year or Datas: 1943-46 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 Widowed 4 N Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry chemical production Elementery/Secondary (0-12) College (1-4or 5+) plant security guard 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be William David Sweadner Grace Dudrear 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9933 Woodsboro Rd. Linda Strawsburg/ sister Frederick, MD 21701 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State Fairmount Cemetery 6/25/98 Libertytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Physician /Medical Immediete Ceuse (Finel ath diseasa or condition resulting in death) RIGHT CORFBROVASCULAR ACCIDENT **Examiner** Due to (or as a consequenca of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificets be associted Zahours after death.

Zahours after death.

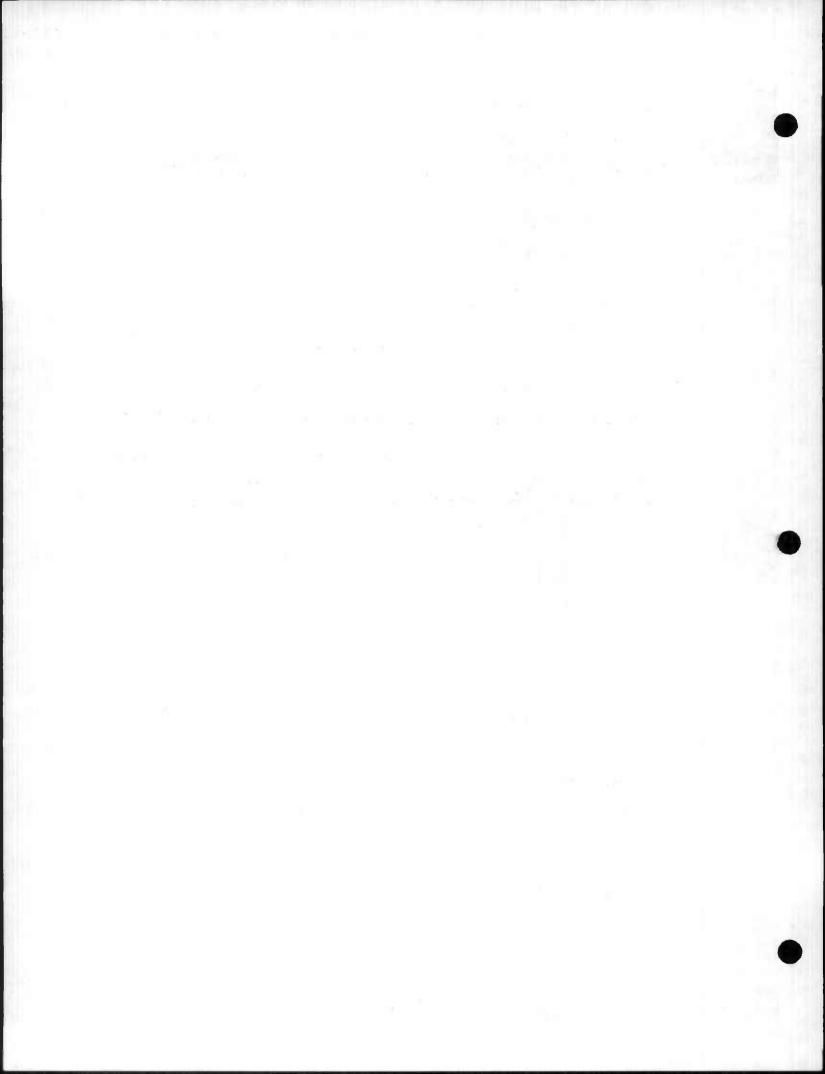
Listeral Director: After this certificate has been signed by the attending physician end attended in by the funeral director, page 2 should be detached for use as the burnal-trensit attely filled in by the funeral director, page 2 should be detached for use as the burnal-trensit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequenca of) P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco uss contribute to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown SOUTRE PERIPHORNE UNSCULAR DISTINGE Records, ð 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Be Completed (& GANGRONE (FOOT) 2 NN0 1 ☐ Yes 2 ☐ No Division of Vital DIABORES CORONARY WORDT DISENSE 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Dey Yeer) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Streat end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Dire complately filled in b Medical 29a. Certifier 🖟 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted. (Check only one) 2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manufer stated. 29b. Signature and title of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) D32171 6/23/98 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) 0 RICHARD L-GOUGH. 19 W PREDORICH ST WALKORSVILLE MD

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 5 1998

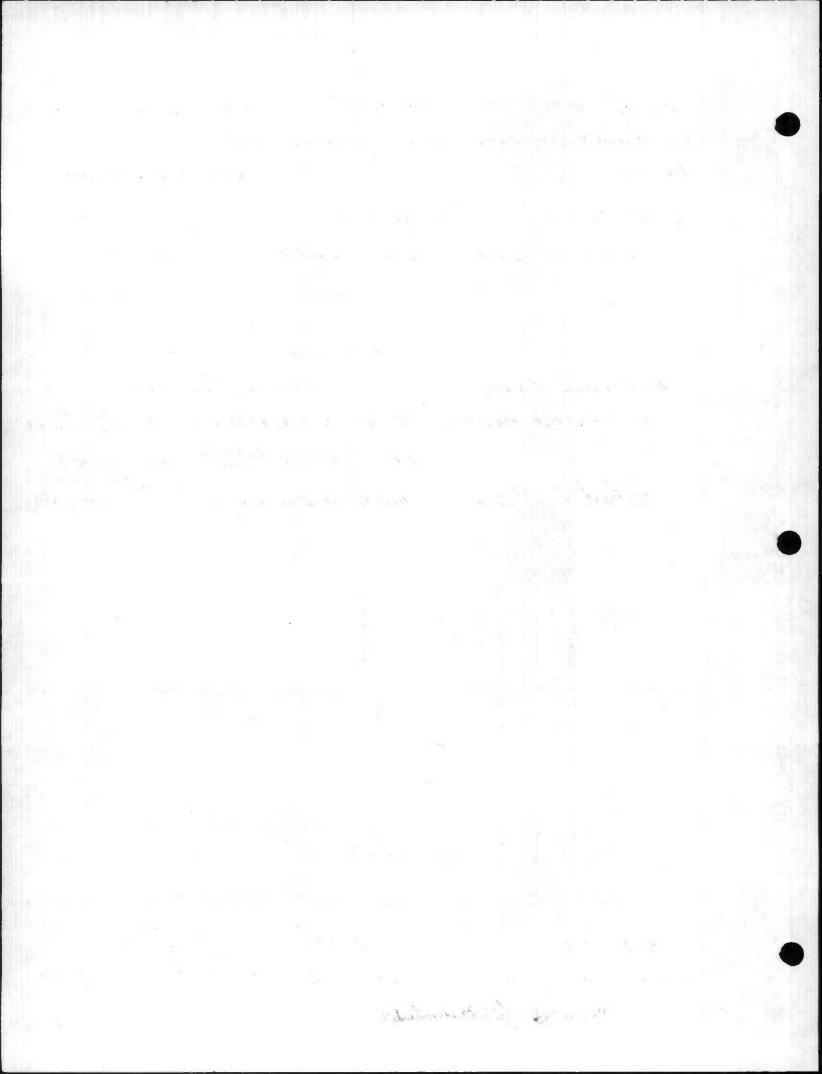


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certif	icate of Death	Re	Reg. No. 98 21288		
Physician	1. Decedent's Name (First, Middle, Lest)				2. Dete of Deett Month	2. Dete of Deeth Month Day Veer 3. Time of Death		
/Medical	MARY CATHERINE		STRAWSBURG		JUNE	19 1998	2:35p	
Examiner	4e. Facility Name (If not institution, give street end numbar)				or Location of Daeth	4c. County of Death		
	WESTMINSTER NO			1 7		CARRO		
Funeral Director	5. Sociel Sacurity Number 2/2-0/-876/ Usuel Residence of Decedent						plece (Stete or Forentry) E444 N	
led within 72 hours efter death with the Maryland tygiene. The "natural", or items 23s or 28s-f show it, the Medical Examiner must be neithfied at Completed by Funeral Director	10e. Stete 10b. County	10	10c. City, Town or Location				10d. Inside City Lim	
	MARGLAND CARROX	-6	WESTMIN	57 ER			1 1 Tes 2 🗆	
	10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 27 EAST MAIN SMEET APARTMENT 21157 4.5, A.							
	11. Maritei Stetus 1 Never Marriad 2 Married 3 Widowed 4 Divorcad	12. Was Decedant Eva Armad Forces? 1 Yas 2 Hoo If Yes, Give Yaer or Dates:	r in U,S. 13. Was	Decedent of Hispenic Origin? s, specify Cuban, Maxican, Pu as 2 PNo Specify:	(Specify Yas or No- erto Ricen, etc.)	14. Race - Ameri Black, White, Specify: 44	cen Indian, , etc.	
	15. Decedent's Ed (Specify only highest gre Elementery/Secondary (0-12)		16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry		
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	19e. Informent's Name/Reletionship (19b. Meiling Ad ER 416	Poole R),	Aurel Route Number, AFARTME	City or Town, State, Zin	O Code) IMINS RR	
	20e. Method of Disposition 1 Burial 2 Cremation 3 4 Donetion 5 Other (Specific	Removal from State	20b. Plece of Disposition	n (Neme of	Dete 2	Oc. Location - City or To	own, Stata	
	21. Signature of Poperal Service Licen		CARRULL CREMATORY Jane 12 HAMPSRAD, MD. 22. Nema and Address of Facility 91 Will's STREET				TREET	
	23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximent intervel Bath						Ten, m	
hysician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es e consequence of):						Intervel Batween Onset end Death	
The law requires that the death certificate be executed atte has been signed by the ettending physician and page 2 should be detached for use as the buriel-transit Completed by Physician/Medical Examiner	Sequentielly list conditions, if eny, leading to immediate ceusa. Enter Underlying Ceuse, (Dissess or Injury	b. Due	Due to (or as e consequence of):					
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						ad? ev	Tere eutopsy finding relieble prior to impletion of cause deeth?	
te hes bage 2					1 □ Yes	2 2 No 1	□Yes 2□No	
To the Hospital or Attanding Physician: The Is within 24 brouns after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	25. Wes cese referred to medicel			26. Place of D	eeth (Check only one)		
	exeminer?	Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
	27. Menney of Deeth 1 Atturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Ye						
			etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Steta)		
	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the ceuse(s) and mannar stated.						teted. the ceuse(s)	
	29b. Signature and title of certifiar	lon		29c. Licansa number	29	29d. Dele signed (Month, Day, Year) 6/20/98 Rein fren, form, Mel 21138		
	30. Name and eddress of person who of	ompleted cause of deeth	(Item 23e) (Type, Print)	- to Diss	Reinfer	form, Me	1 2113	
State	31. Dete filed (Month, Dey, Year)	32. Registrer's	Signeture					

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) June 26, Day 1998 2:25 AM Carolyn Lee Sizemore 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Geroge's Clinton if Under 24 Hrs If Under 1 Year Months Days 8. Date of Birth 9. Birthplace (St. Month, Day Year) 1945 Indiana 5 Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 ☐ M 2 ☐ F 52 315 46 0690 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County P.G. Clinton 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20735 6700 Danford Drive 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married 1 Yes 2 No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) 12 Necular Medicine Tec. Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Elsie Osterman Alonzo Armstrona 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jessie S. Sizemore, Sr. 6700 Danford Drive, Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 28, 14998 20c. Location - City or Town, Stete Buriel 2 Cremation 3 Removal from State Cheltenham, Maryland Maryland Veterans Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Licenses Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset end Deetl Immediate Cause (Final disease or condition resulting in death) A351V 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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Certification: To

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The law requires that the death certificate be executed

P.O. Box 68760.

Records.

Division of Vital or Attending Physician: efter death.

Physician

/Medical

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MD

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, in a legical Experiment can be notified at

Baltimore, Maryland 21215-0020

Examiner Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

24a. Wes an autopsy 1 Yes

24b. Were eutopsy findings eveileble prior to completion of cause of death?

2 No

28d. Describe how Injury occurred

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27	Manner of	Dooth
	examiner?	

5 Pending Investigation

6 Could not be determined

XTENSIVE

28a. Date of Injury (Month, Day Year)

28b. Time of

1. Inpatient 2 ER/Outpetient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Tes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident 3 Suicide

4 Homicide

29b. Signeture end title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of perso who completed ceuse of death (Item 23e) (Type, Print)

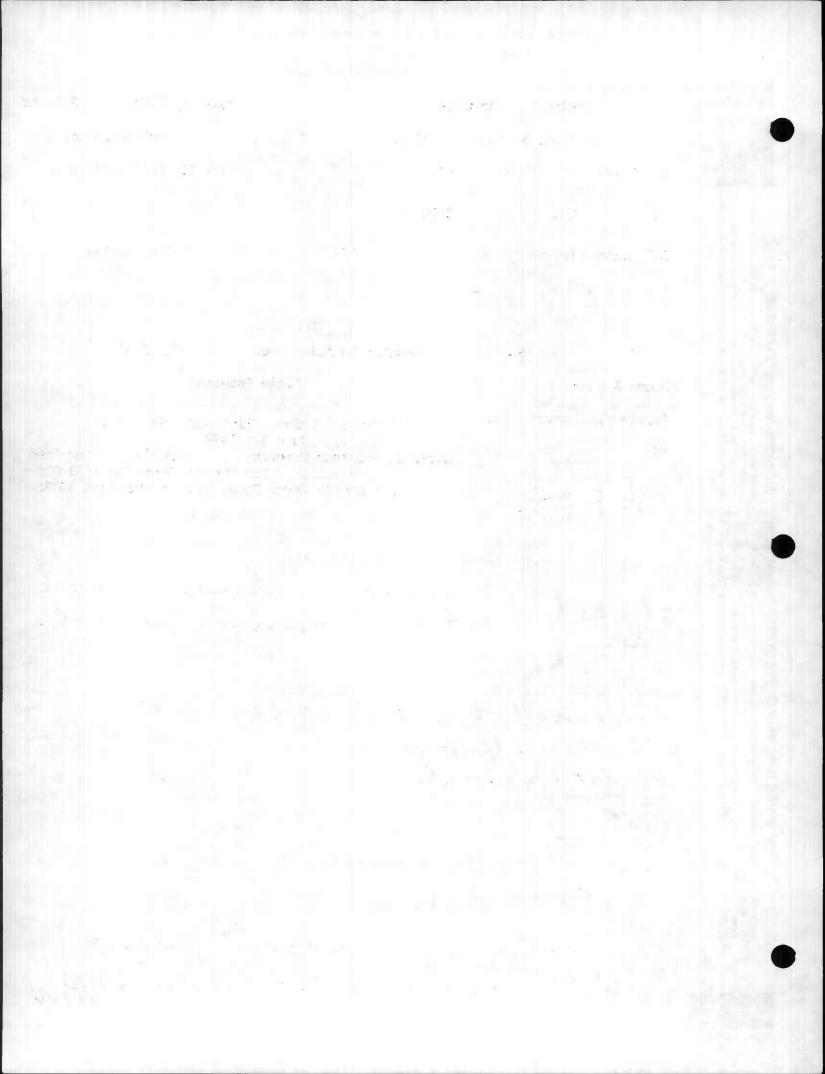
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Date filed (Month, Day, Year) JUL 01

32. Registrar's Signature

State Registrar

Jali Studier Raylell



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Frank Lexington Simpson, III 1998 July 1 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 619 Bayside Drive Queen Anne's Stevens viii If Under 24 Hrs. 8. Data of Birth (Month, Day Year) July 11,195? Stevensville if Undar 1 Yaar Months Days 5. Social Sacurity Number Birthpiaca (State or Foreign Country) 7. Aga (In yrs. last birthday) Months XXM 2 F Yrs 215-70-2400 40 Maryland Usuai Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas ANO Oueen Anne's Stevensville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 619 Bayside Drive 21666 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 X Xes 2 ☐ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yas 2000 Specify. White Specify: 3 Widowed 4XDSivorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usuai Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) U. S. Navy Elemantary/Secondary (0-12) Collega (1-4or 5+) Machinist-Engineer Tech. 12 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Frank L. Simpson, Mary Bauer 19e. tnforment's Name/Raietionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Mrs. Carol King (Sister) 804 Wisteria Dr., Westminster, Md. 21157 July 3,1998 20c. Location - City or Town, Stata 20b. Piece of Disposition (Name of camatary, cramatory or other place) 20a, Mathod of Disposition 1 ☐ Burlai ※XI Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Stevensville, Md. Chesapeake Cremation Center 21. Signatura of Funarai Sarvice Licansaa 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home 23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiretory arrast, shock, or heart feilure. List only one cause on each line. Rubein 106 Shamrock Rd., Chester, Md. 21619 immediate Causa (Final diseasa or condition rasulting in deeth) Jampa at Dua to (or as a consequence of) Sequentielly list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or injury that initiated evants rasulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♠ Unknown 24a. Was an autopsy 24b. Wara autopsy findings available prior to performed? completion of cause of deeth? 1 Yas 2 No 1 Yas 2 No 26. Pieca of Daath (Check only ona)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. Stata

Md.

Directo

Funeral

à

Completed

Be

9

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinal must be nothed at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n any filury or other traumatic event, if a Med 2008.

with the Maryland

72 hours after death

altimore, Maryland 21215-0020

attending physician and for use as the burial-transit the a signed by peen

The law requires that the death certificate be executed

Box 68760

P.0.

Division of Vital Records,

Physician/Medical Examiner

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Completed

Be

9

Certification:

Medical

certificate has or Attending Physician: after death. After this funeral Director: n 24 hours after der Ne Funerel Directo pletely filled in by th

25. Wes casa rafarred to medical axaminar?

1 Yes 2 No 27. Mennar of Death

1 Naturai 2 Accidant 3 Kl Suicida 4 Homicida

29a. Cartifiar

(Check ann)

29b. Signature and title of certifier

5 Panding invastigation

6 Could not be datarmined

Hospital: 1 ☐ inpatiant 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year)

-1-98 28e. Piece of injury - It home tarm, street, factory, office building, atc. (Spinchy)

Jones

28b. Tima of injury Willyour M

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and menner as stated.

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred Work

Location (Street and Number or Rural Route Number, City or Town, Stata) 619 Payside Herande

2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

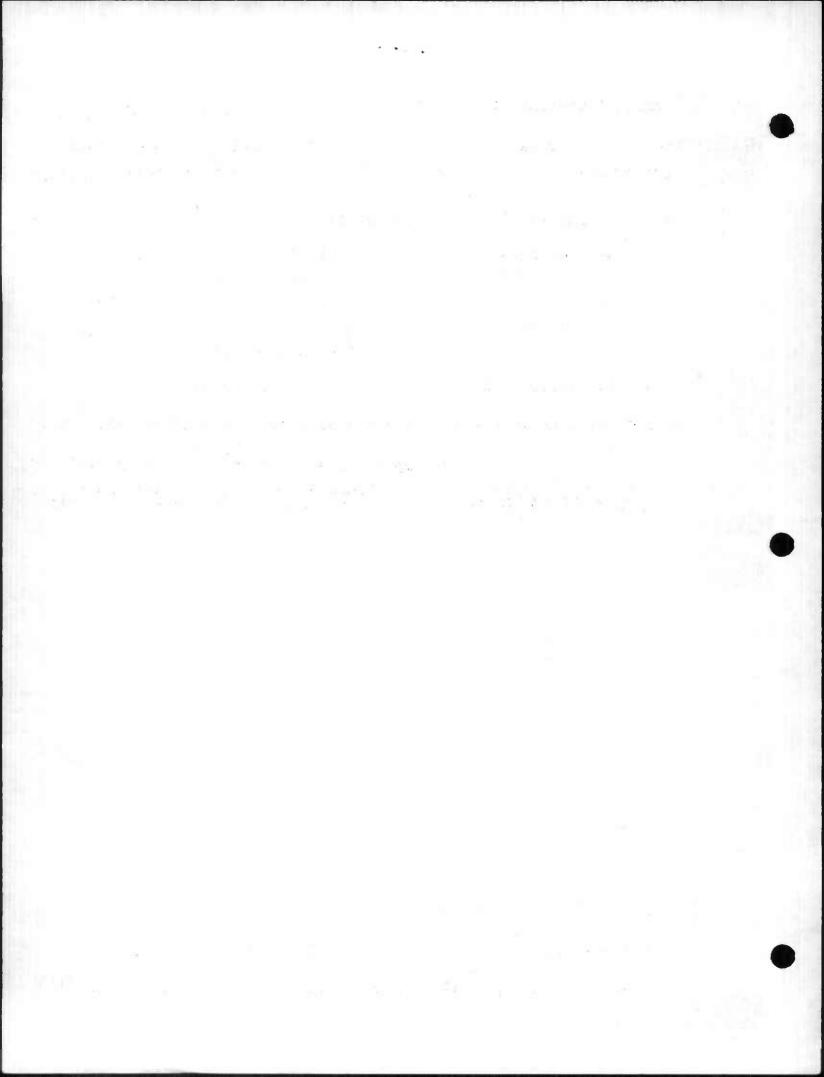
30. Name and address of person who completed cause of death (itam 23a) (Type, Print)

204 Medical Center Rd., Grasonville, Md.

State Registrar

Ralph S. Libby, M.D. 204 I Data filed (Month, Day, Year) 32. Ragistrar's Signatura 31. Data filed (Month, Day, Year) una Davidson- Mandala JUL 0 6 1998

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State of Maryland / Department of Health and Mental Hygiene 🍳 🤉

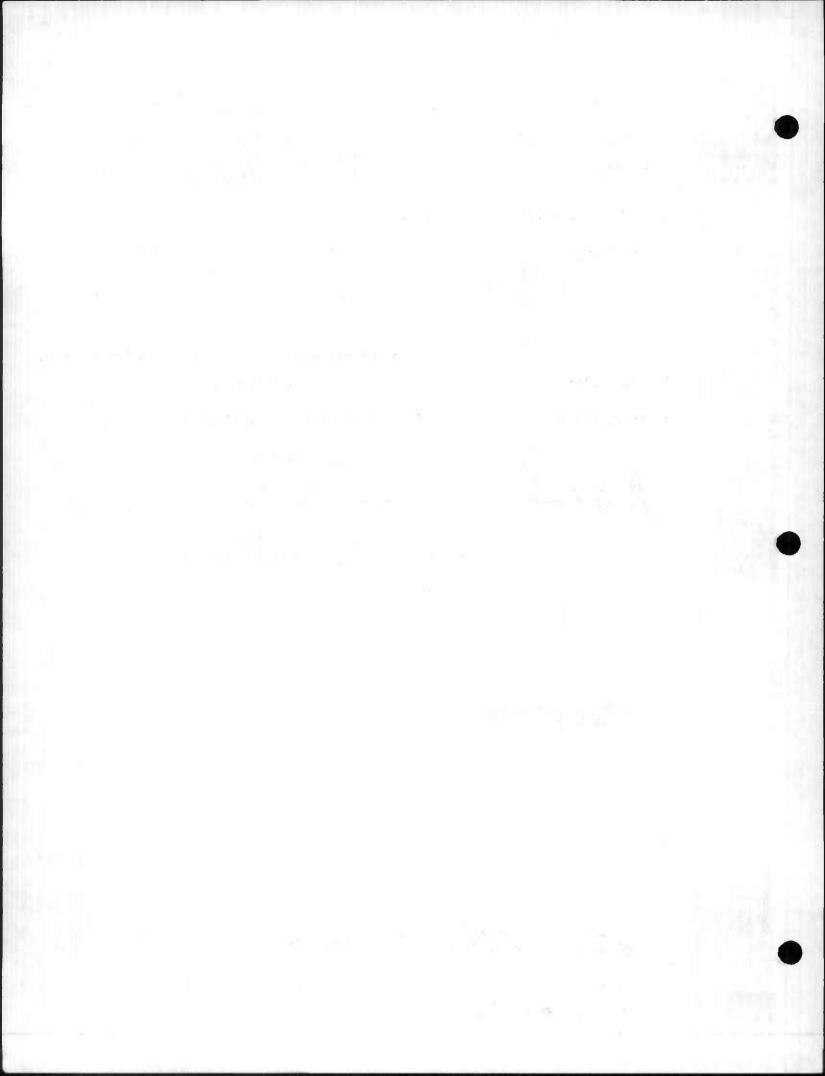
Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** William Raymond Willey 30, June 1998 1:30 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2705 Greenbrier Road Cambridge Dorchester If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Dey, Year) 5. Social Security Number If Undar 1 Year 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 □ F Deys 212-36-6123 Yrs. Director 9,1939 Maryland Usual Residence of Decedani with the Maryland 10e Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, it a Medical Examiner must be notified at Maryland Dorchester Cambridge 1 Yas 2 XNo Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2705 Greenbrier Road 21613 US death 12. Was Decedant Ever In U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Giva Yaar or Dates: 11 Marital Status Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after or nont of Health and Mental Hygiene. nnt: If Item 27 is marked other then "natural", or item 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes X No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent'a Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Equipment Operator County Highway Dept. 17. Fether'a Nema (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Selvin Willey Ethel Wroten 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat end Number or Rural Routa Number, City or Town, State, Zip Code) Brenda J. Willey 2705 Greenbrier Road Cambridge, Maryland 21613 Wife other 1 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 8 XBurial 2 Cramation 3 Ramoval from State permit. Page Department of important: If any injury or once. Dorchester Memorial Park 7/3/98 5 Othar (Spacify) Cambridge, Maryland 22. Name and Addrass of Facility
Thomas Funeral Home, P.A. Funeral Sarvice Licensaa 21. Signatura Entar tha diseasa, or complications that causad the death. Do not antar the mode of dying, such as cerdiac or respiratory arrast, or heart failure. List only one cause on each line.

700 Locust Street Cambridge, Maryland 21613
Approximate Approximata Interval Batwaen **Physician** andreie /Medical Immediata Cause (Final disease or condition rasulting in death) **Examiner** Examiner ed by the attending physician and detached for use as the burial-tran Sequantially list conditions, if any, leading to immadiate causa. Entar Underlying Cause (Disaase or Injury that initiated evants resulting in daath) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 □ Unknown Honorea þ 24b. Wara autopay findings availabla prior to complation of ceuse of death? Completed 24a. Was an autopsy certificate has 1 Yas 20 No 1 ☐ Yas 2 ☐ No 25. Was cesa refarred to medical Be 26. Place of Deeth (Check only ona) axaminar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yaa 2 No 10 this filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Certification: 28a. Data of Injury (Month, Day Year) 28b. Time of After NA Natural 5 Panding invastigation il or Attending s after death. il Director: Aft NIA 1 Yas 2 No NIA 2 Accidant NIA 3 Suicida 6 Could not ba 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) 4 T Homicida To the Hospital or within 24 hours aff To the Funeral Di completely filled in edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, and due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of exemination and/or invastigation, in my opinion, death occurred at tha time, data and place, and due to the ceuse(s) and mannar stated. (Check only one) 29b. Signature and title of couling 29c. Licensa number 29d. Data algned (Month, Day, Year) DO50799 Theme and addrass of person who complated ceuse of death (Itam 23a) (Type, Print) SHIRIN MOHAMMAD COLLINS AVE., HURLOCK, MD 21643 302 32. Registrar's Signature 31. Data filad (Month, Dey, Yaar) State

DHMH 16 Ray 6/95

Registrar

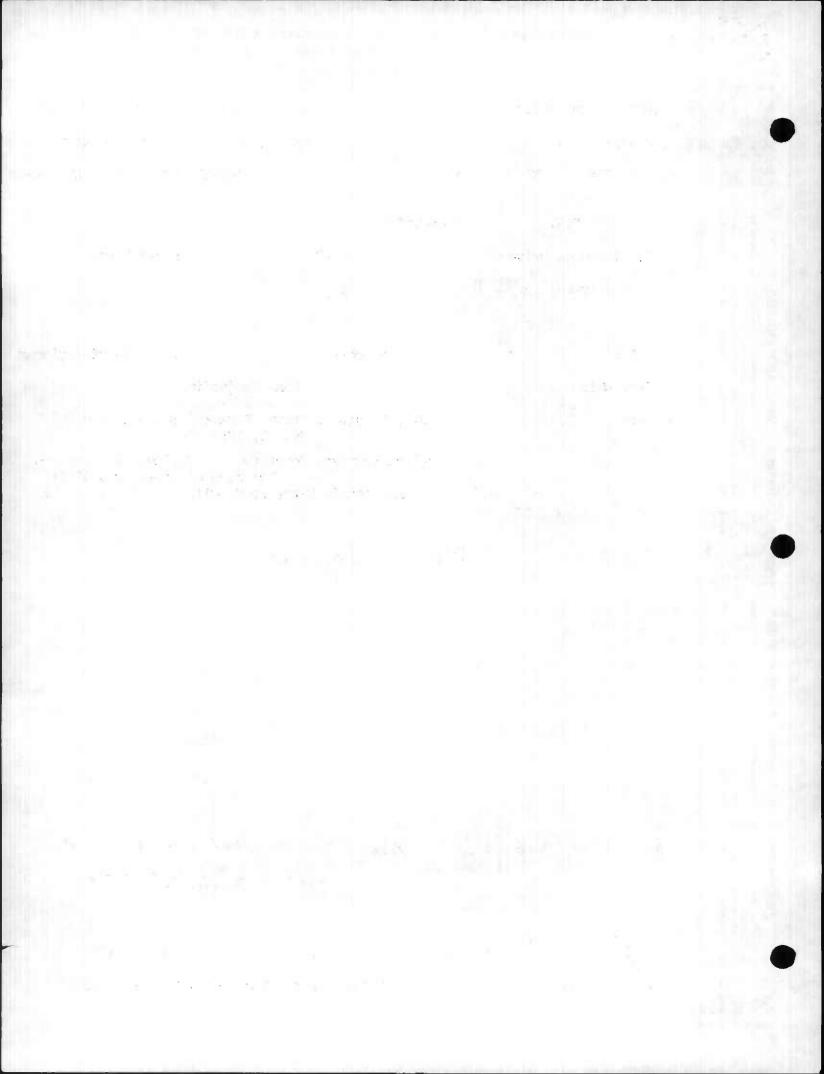


98-3662-033 RICHARD A. WHITE

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 21292

<u></u>	1		•	Ce	ertificate of	Death	R	eg. No.	5 6	1636
	D1 - 1 1	1. Decedent's Name (First, Middle, L	ast)				2. Dete of Deet Month	h Dey	Yeer	3. Time of Deeth
1	Physician /Medical	Richard Andrew V	hite				JUNE 25			0935AM
	Examiner	4e Fecility Neme (If not institution, g	ive street end number)			4b. City, Town, or	Location of Deeth	4c. County	of Deeth	
		MALCOLM GROW HO	SPITAL			CAMP SPR			E GEOR	RGES
	Funeral Director	5. Social Security Number 6. 020 22 5714	Sex 7. Age (in 1	yrs. lest birthday 9 Yrs.	Months Days			Year) 1928		ce (State or Foreign y) nster, Mas
	p ,	Usuel Residence of Decedent 10e. State 10b. County	10-	. City, Town or I	ties				100	d toolde Ob. Lloin
	anyla show								100	d. Inside City Limits 1 ☐ Yes 2 ☐ No
	be M	MD P.G.	Fo	orestvi.			Т.			Δ
	Oir Dir	10e. Street and Number	D 1		10f. Zip Code			0g. Citizen of \		
	23a	3710 Kingswood		h 110	2074			United	State a - American	
020	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other tuna "natural", or Itema 23a or 28a-f show aumatic event, tra Medical Examiner must be notified at TO Be Completed by Funeral Director	11. Maritel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? XX Yes 2 No 11 Yes, Give Yeer or Detes:	in 0,5.	If Yes, specify Cu	Hispenic Orlgin? (S ben, Mexicen, Puer Specify:	to Rican, etc.)		ck, White, et	
0	2 ho	15. Decedent's I		16e. Dec	edent's Usuei Occi	upetion	and a far on	16b. Kind of B	usiness/Indu	stry
2	be filed within 72 hor tall Hygiene. If other then "neture event, the Medical Be Completed	(Specify only highest g Elementery/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use retir	e during most of wo red)	inking			
7	d wit	12	4	Geo	ographer			U.S. Co	orp of	Engineer
9	al Hygie I other vent, u	17. Fether's Neme (First, Middle, Las	(1)			18. Mother's Ne	me (First, Middle, i	Meiden Sumen	ne)	
N N	should be and Mental I american or immetic eve	Andrew White				Ida I	Desjardin	ıs		
2	s 1 and 2 should f Health and Men tem 27 le marke other traumatic	19e. Informent's Neme/Reletionship Barbara Whit				et end Number or R d Drive,	Forestvi			
an a	of He of Herr	20e. Method of Disposition	20	b. Plece of Disposery, cr	position (Neme of remetory or other p	July 1	1298	20c. Location -	City or Tow	n, Stete
Ē		Buriel 2 Cremetion 3 4 Donetion 5 Other (Spec	_ Remover from State			s Cemeter	ry c	helten	nam, M	laryland
alti	permit. Peg Depertment Important: I any Injury o	21. Signature of Funeral Service Lice	- 34			ress of FecilityLe	-			4
m	S E E E	Van et	11/4	A	lexandria	Ferry Ro	oad, Clin	ton, Ma	arylan	d 20735
	The law requires that the death certificate be executed It has been signed by the ettending physician and page 2 should be detected for use as the buriel-transit Completed by Physician/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest	c. Due t	to (or es e cons	equence of):	uries				
). Box	es thet the death cer igned by the ettendir be deteched for use by Physician/A	Pert II. Other significent conditions	contributing to death but not	resulting in the	underlying ceuse (given In Pert I.	23b. Did to	obacco use co	entribute to t	the cause of death?
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of Vital Records,	The law requires the set has been signed, pege 2 should be d						24e. Wes e	en eutopsy med?	evei	re eutopsy findings leble prior to pietion of cause eath?
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ā	entificet sctor, p	25. Was case referred to medical				28. Plece of De	eth (Check only or			
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0	Physerthis eral di	27. Menner of Death	28a. Date of Injury (Month, Day Yea				28d. Describe h			
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Division	tal or Attending P rs efter deeth. al Director: After t ied in by the funers Certification:	3 Suicide 6 Could not determine	be 28e. Place of Injury	At home, ferm,	street, factory, offic	θ,	28f. Location (S	treet end Numi	ber or Rurel	Route Number,
	Set in Die	4 Homicide	building, etc. (Sp	oecny)	57	treet	Forresty	n, Stete)	arkway	_
	To the Hospital or Attending Physician 24 hours deter deeth. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		hysician: To the best of my miner: On the besis of exar end menner steted.				e, end due to the c	euse(s) end m	anner es ste	
	To the within To the somp	29b. Signeture and title of certifier	101		29c. Lice	nse number	2	29d. Dete signe	ed (Month, D	ey, Year)
		/(//	11/2/2/2	9	0.0	.M.E.		JUNE 26	100	8
		30. Nemerand eddress of person with	ampleted cause of death	(Item 23e) (Type		• 1 1 • Li •		JOIND Z	1 100	
		Vennis	Chute mi			street, Ba	altimore.	Maryla	and 21	201
	State	31. Dete filed (Month, Day, Year)	32. Registrer's S	ianeture						
	Registrar	JUL 0 1 19	18 Tun Dave	dear Rand	R					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 9:43PM June Thomas Joseph Wolf 30,1998 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2 F 218-36-1423 Nov. 27, 1939 Maryland Director Usuel Residence of Decedeni the Meryland 10c. City, Town or Location 10a State 10b. County 10d Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tra Modical Examinar maint be notified at Queen Anne's 1 ☐ Yes 2 X No Director Stevensville Md. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 216 Pennick Dr. 21666 U.S.A.

14. Race - American Indian, Funeral 12. Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2000 Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mentel rhygiene. I important: If Item 27 is marked other than "natural", or ther any injury or other traumatic event. 1 Never Married 2 € Married Saltimore, Maryland 21215-0020 1 Yes 2 XXX Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedant's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry State of Md. Annapolis Bldg. 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Carpenter 10 Grounds 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Malden Surname) Be Marie Breighner Joseph Wolf (Wife) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 216 Pennick Dr.; Stevensville, Md. 21666 Mrs. Patricia A. Wolf 20b. Place of Disposition (Name of cometary cramatory or other place)

Meadowridge Cemetery 20a. Method of Disposition July Dets, 1998 Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Elkridge, Md. 4 ☐ Donation 5 ☐ Othar (Spacify) 22. Name and Address of Facility 21. Signatu Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Rd., Chester, Md. 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one reuse on each line. **Physician** /Medical Immediata Causa (Final diseese or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760, physician certificate be Physician/Medical Due to (or as a consequence of): ettending ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? signed by d be detacl 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No Smoker Records, à 24b. Were autopsy findings availabla prior to completion of cause of death? 24e. Was en eutopsy Completed peen 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: director, Be 25. Was casa referred to medical 26. Place of Daath (Check only ona) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation Natural death. 1 Yes 2 No 2 Accidant i or Attend after death Director: 3 Suicide 6 Could not be detarmined 28a. Place of injury - At homa, farm, street, factory, offica building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours af To the Funeral DI completely filled is 29a. Cartifier Textifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner se stated.

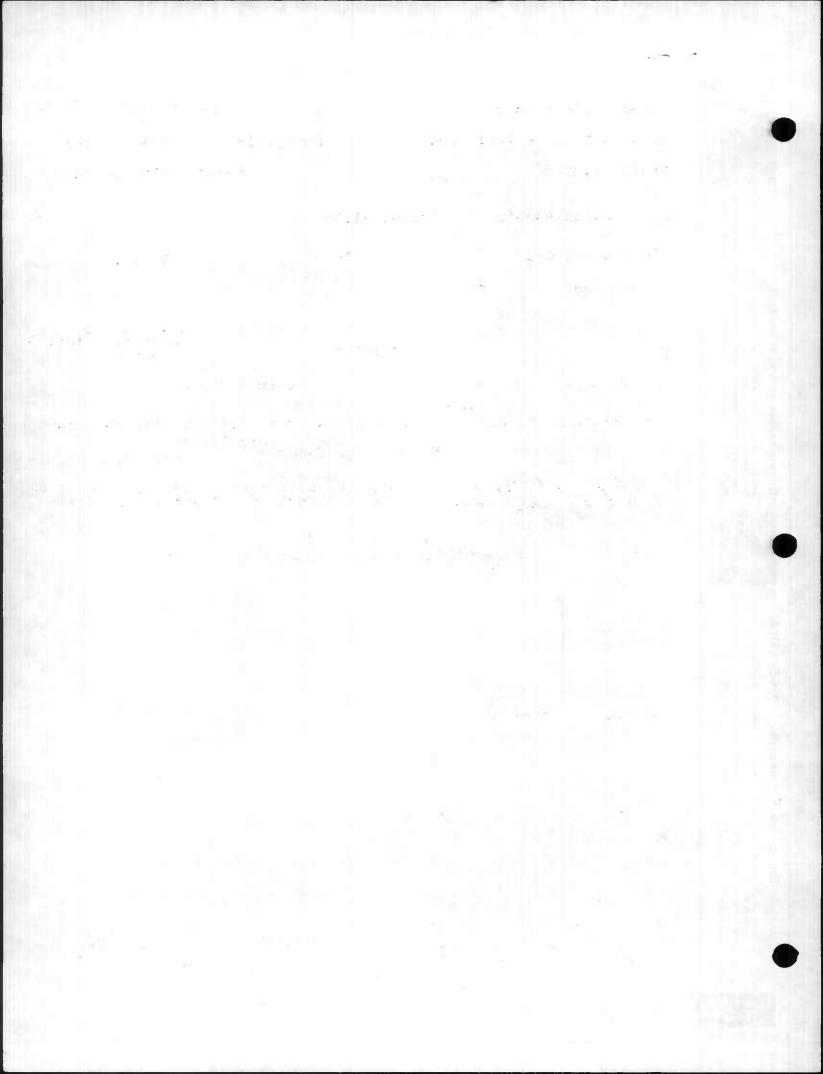
Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 6/30 Franklin 30. Name end addrass of person who completed cause of death (Item 23a) (Type, Print) Medical W. MD, Anne Arundel MD 21401 Charles hel 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature

Registrar **DHMH 16 Rev 6/95**

State

JUL 0 2 1998

Mia Davidson



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death Month Vaar May 8, 1995

1 Death 4c. County of Death **Physician** Joseph Adams, Sr. 3:55pm /Medical 4a. Facility Nama (If not institution, give street and number) 18101 Prince Phillup City, Town, or Location of Death Examiner Drive Olney, MD Montgomery Montgomery General Hospital If Undar 24 Hrs. Hours Min. If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 11XM 2□ F Months 251-40-3982 69 Director Sept. 30,1928 Edgefield. SC Usual Rasidance of Decedant the Maryland 10b. County 10a. Stata 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at XXYas 2 No Director Maryland Montgomery Silver Spring, Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2601 Bel Pre Road 20906 USA Funeral death 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 11. Marital Status 12. Was Decedent Evar in U.S. permit. Pages 1 and 2 should be filled within 72 hours effer. Department of Heelth and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or item any Injury or other traumatic event, the Medical Exemples once. 1 ☐ Yas 2 🛣 No 1 ☐ Nevar Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yas 2 X No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Truck Driver Hutcherson Brothers 12th 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Mary Lizzie Adams Henry Adams P 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 369 54th St., NE Washington, DC 2001 19e. Informant's Name/Reletionship (Type, Print) 20019 Hattie McKinney/daughter 20a. Method of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 1XXBurial 2 Cremation 3 Ramoval from Stata Mount Zion Cemetery 6/15/98Baltimore, 4 ☐ Donation 5 ☐ Othar (Specify) Maryland 22. Nama and Addrass of Facility Latney's Funeral Home, Inc 21. Signature of Funarai Service Lice 3831 Georgia Ave., NW Wash., DC 20011 comon 23a. Part1. Enter the disease, or compositions thet caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Cardio Pulmonary and Renal Failure weeks **Examiner** Dua to (or es e consequence of): Physician/Medical Examiner Atrial Fibrillation years physician and the burial-tran Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disaase or Injury that initieted events rasulting in daath) Last Dua to (or as a consequence of): Hypertensive Cardiovascular Disease years Box 68760, certificate be Dua to (or as a consequanca of): 88 950 ō signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Myelogenous Leukemia by 24b. Wara autopsy findings available prior to complation of cause of death? 24e. Was an autopsy Completed peeu page 2 has 2 No 1 ☐ Yas 1 TYes 2 No certificate Be 25. Was casa refarred to medical axaminar? 26. Place of Death (Chack only ona) in 24 hours after death.

the Funeral Director: After this of Hospital: 1 Inpatiant 2 □ ER/Outpatient Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No 3□ DOA 2 27. Mannar of Daath 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Dey Yeer) 28b. Tima of 28c. Injury at Work? Certification: 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not ba 3 ☐ Sulcida 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowladga, daath occurred et the time, dete end plece, and dua to tha cause(s) end menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, daeth occurred et the tima, dete and plece, end dua to tha causa(s) and mannar statad. 29a. Certifier Medical (Check only one) Within 2 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of certifiar May 9, 1998 (W) 30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print) Cezar A. Lopez, MD 18111 Prince Philip Drive Olney, Maryland 31. Data filad (Month, Day, Year) 32. Registrar's Signatura

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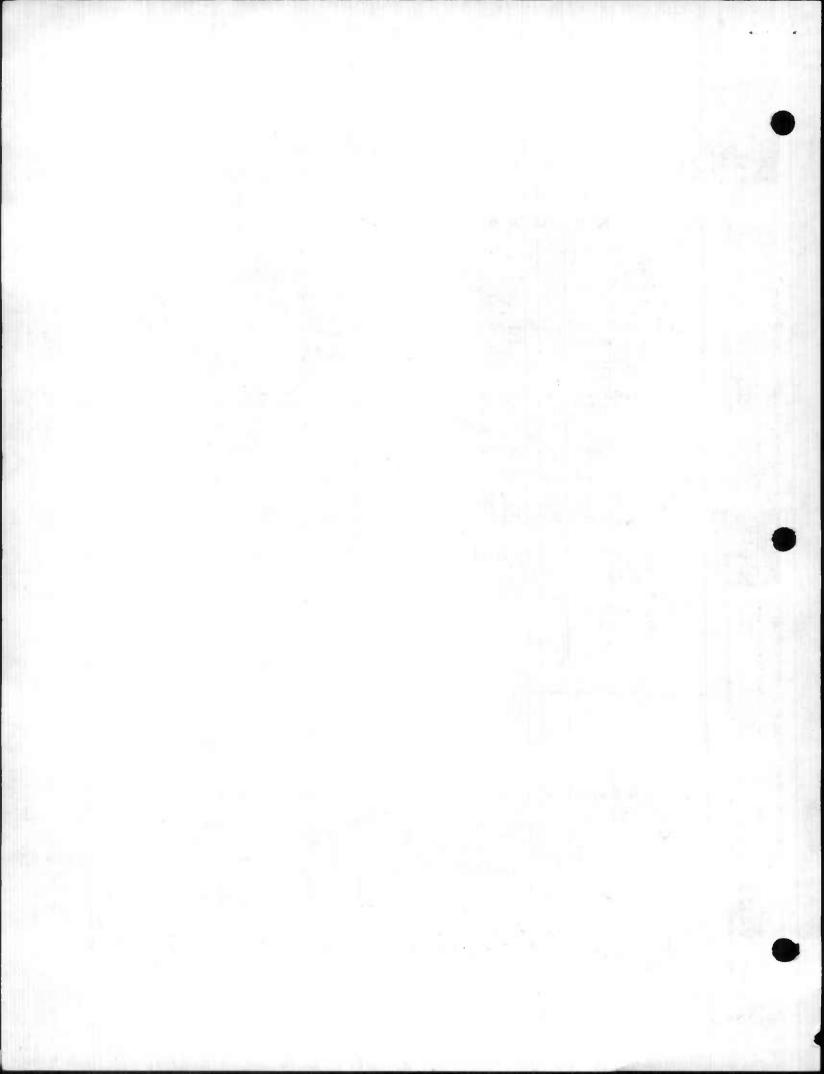
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Dala of Death Month **Physician** /Medical 4a Facility Nama (If not institution, giva s 4b. City, Town, or Location of Death 4c. County of Death Examiner ltimor 9. Birthplaca (Stata or Foraign Country) If Under 1 Ye 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Months Min 1 M 2 KF Yrs. Director **Usual Residence of Decedent** death with the Maryland 10b. County 10c. City, Town or Location 10a. Stala 10d. Inside City Limits ahow forms 23s or 28s-f short ther must be notified at 1 Yas 2 No ownshi Director Pennsylvania Northumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 () No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene, Important: If then 27 Is marked other than "natural", or fram any injury or other treumatic avent, the Medical Exercises Once. Black, Whila, alc. 1 ☐ Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 25 No Specify: Specify: While 3 ☑Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 YRS 17. Father's Nema (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumeme) Be 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19q. Informant's Name/Ralationship (Type, Print) July 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Sleta 14 1 Burial 2 Cremation 3 Permoval from State Kennsylvano 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility vans LIMONIUM 23a. Part1. Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresl, shock, or heart feiture. List only one cause on each line. Approximata Intarval Batween Onset and Death Physician roscliratic cardiovascular disease Immediate Causa (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): The law requires that the death certificate be exp P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed After this certificate has 2 No 1 Yes 1 ☐ Yas 2 ☐ No or Attending Physician: funeral director, 25. Was casa referred to medical axaminer? Medical Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 1 Accident 5 Pending investigation after death.

I Director: Aff
in by the fur 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral Di 1 MC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address of person who of death (Item 23a) (Type, Print) 32. Registrar 31. Data tiled (Month, Day, Year) wha Davidson Randell State Registrar

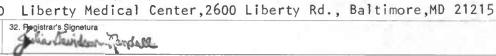
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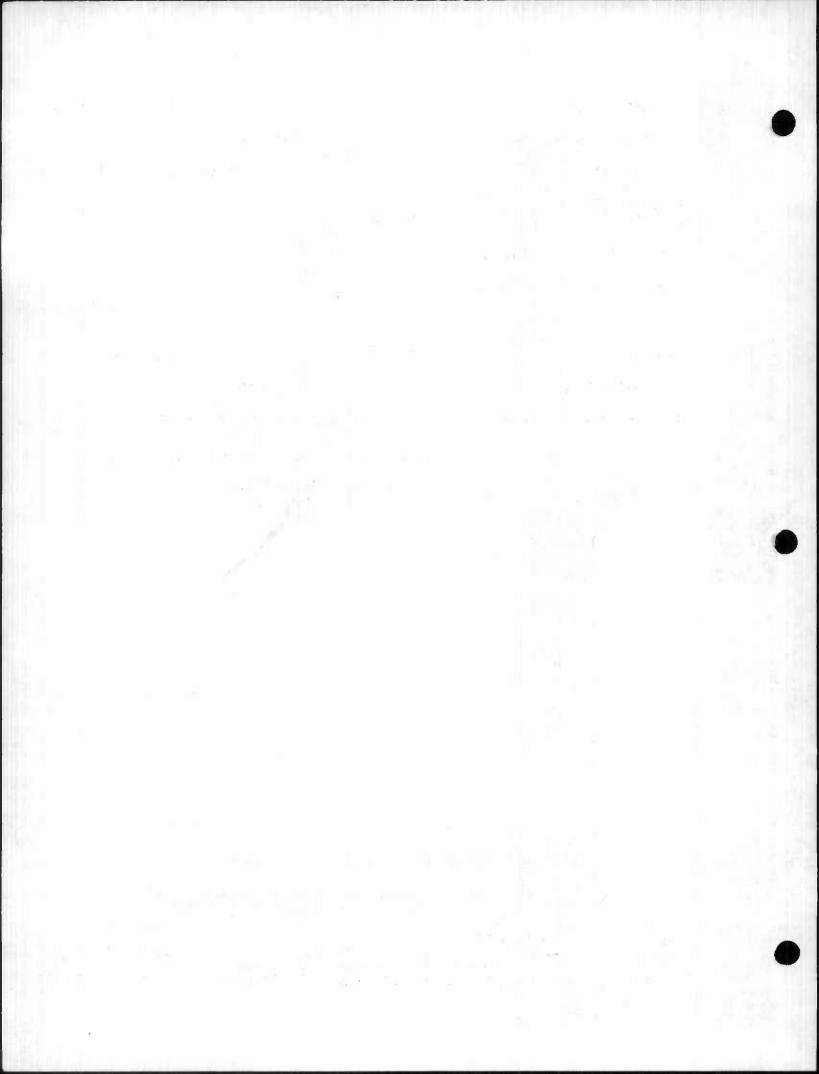
State Registrar Sudmir D. Patel, MD
31. Data filed (Month, Dey, Year)
JUL 131998

30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print)



D23300

May 22, 1998



wie Davidson

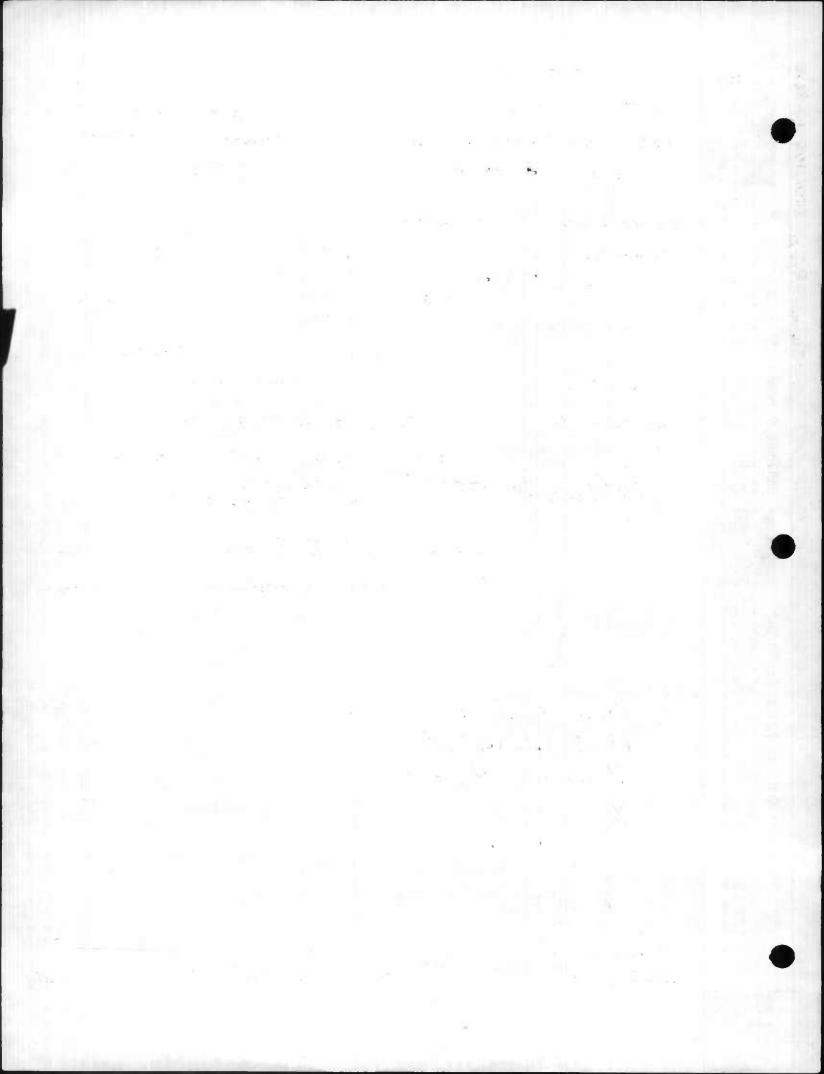
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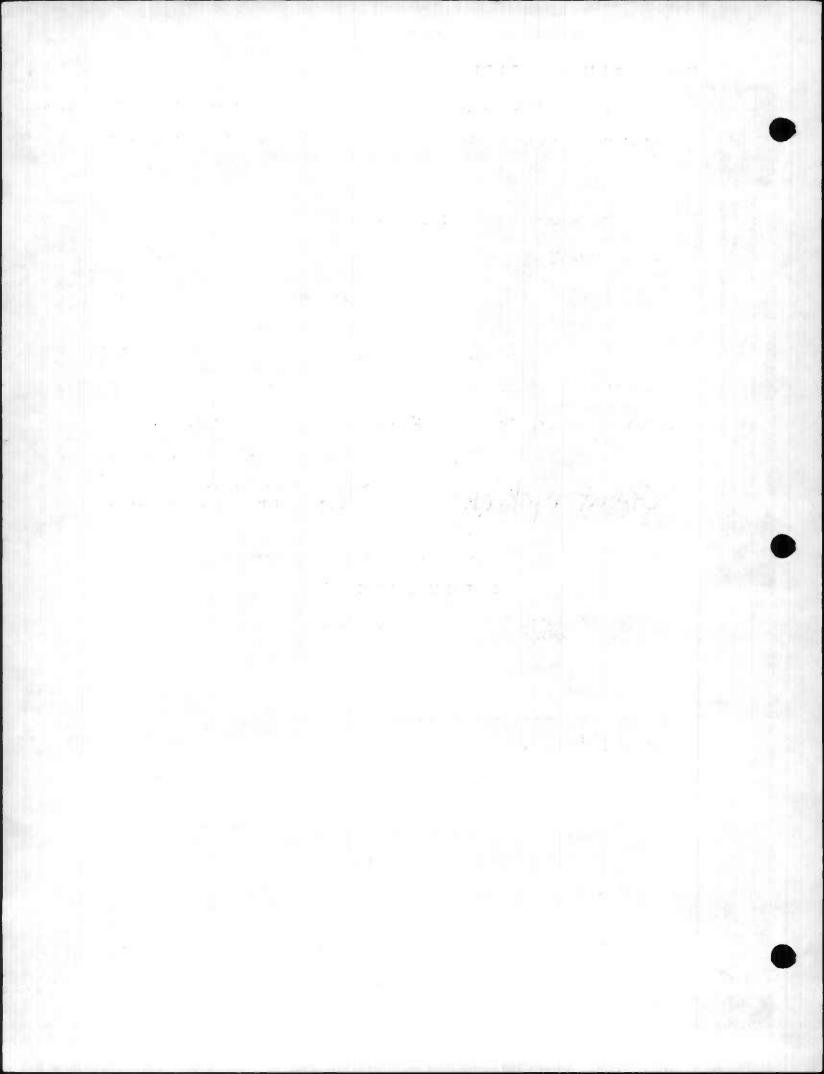
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31. Date filed (Month, Dey, Year)

JUL 131998



4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park 4c. County of Death Montgomery 45. Social Security Number 216-30-5712 180 M 20 F 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. 8. Date of Birth (Month, Qay, Year) 9. Birthplace (State or Foreign (Month) 1 (Month, Qay, Year) 1 (County) 1 (County)	1. Decedent's Name		o OGLAS BALL	ARD					2. Date of De Month June	eath 27	1998	3. Time of Death 1:17 a.i
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27. Mannar of Death 1 Shatural 5 Panding investigation 2 Ba. Data of Injury 2 Bb. Time of Injury 4 Work? 29. Accidant 3 Sulcida 6 Could not be determined 2 Ba. Place of Injury - At home, tarm, streat, factory, office 2 Ba. Certifier (Check only one) 2 Certifying Phyelclan: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.	25. Was casa ratarre axaminar?							lace of De	ath (Check only	ona)		
29a. Certifier (Check only one) 12 Gertifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.		5 Panding	1 LI Inpatie		8b. Time of	28c.	Injury at Work?					ify)
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D 46398 June 29, 1998		tle of certifier				29c. L	lcense numb	er		29d. Date si	gned (Month	Day, Year)
	6.6	mpta	, mo			D	463	98		June	29	1998



A		State of Maryland / Department of Health and FH Film G761 7-23-98RC Certificate of Death	l Mental Hy	giene	21299
Amend: #5	Per	FH Film G761 7-23-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No.	3. Time of Death
	ysiciai	ANTOUT A DAILT IND DITIACO	Month /	Day	98 1:50 am
	Medica kamine		or Location of Dea		
1000		Charlestown Care Center Cator	rsville	Bo	altimore
100000	neral	5. Social Security Number 217-32-0481 $1 \square$ M 2 \square F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F Months Days Hours M	in. (Month, D	rth ay, Year)	Birthpiace (State or Foreign Country)
	etor	Usual Residence of Decedant	Sept.	10, 19	003 Maryland
nylane	19	10a. State 10b. County 10c. City, Town or Location			10d. inside City Limits
Me Me	be notified at	Maryland Baltimore County Catonsville			1 ☐ Yes 2 No
with th	De no	10e. Sfreet and Number 10f. Zip Code		10g. Citizen of V	
eath a	ner must	701 Maiden Choice Lane 21228 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 12. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 13. Was Dacedent of Hispanic Origin? 11. Hyes, specify Cuban, Maxicen, Pu 11. Yes, specify Cuban, Maxicen, Pu 11. Yes, specify Cuban, Maxicen, Pu 11. Marital Status 12. Marital Status 12. Marital Status 13. Was Dacedent of Hispanic Origin? 11. Hyes, specify Cuban, Maxicen, Pu 11. Yes, specify Cuban, Maxicen, Pu 11. Yes, specify Cuban, Maxicen, Pu 11. Marital Status 12. Marital Status 13. Was Dacedent of Hispanic Origin? 11. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 13. Marital Status 14. Marital Status 12. Marital Status 12. Marital Status 12. Marital Status 13. Marital Status 14. Marital Sta	(Specify Ves or N		SA a - American Indian,
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21215-0020 d within 72 hours aft gjens "netural", ov	Exe	3 ☐ Widowed 4 ☐ Divorcad if Yes, Give Yaar or Dates:		Specify	White
15-(172 h	Medical	15. Decadent's Education (Specify only highest grade completed) (Give kind of work done during most of ville. Do NOT use retired)	vorking	16b. Kind of Bu	usiness/Industry
vithir	Tre Me	Elamentary/Secondary (0-12) College (1-4or 5+)		Enoch	Pratt Library
DI Pilled	ent,	2 yrs Librarian 17. Father's Neme (First, Middle, Last)	lame (First, Middle	, Maiden Suman	10)
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Menyland his and Mennill Hyglens. 71 is marked other than "netural", or items 23s or 28s-4 show	atic ev	Melchior Budacz Ma	rie	Zac	zak
Mary 2 sho and is me	mne.	19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or	Rural Route Numb	er, City or Town,	Steta, Zip Code)
	other traumatic event,	Arthur L. Budacz (Brother) 1544 Upshire Road, B			
Baltimore, semit. Pages 1 ar Department of Han Moortant: if Itan	0.0	1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	Date		City or Town, State
Iltin	Cinfu	4 Donation 5 Other (Specify) 21. Signature of Fungrai Service Dulaney Valley Mem Grdns 22. Nama and Address of Facility	7/15/98	Timoniu	m, Maryland
Balt permit. Departu	any is	6500 York Road			
		Martin D. Lawson Baltimore, Maryl 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	and 2121	2. arrest,	Approximata
Physic	cian	snock, or neart failure. List only one causa on each line.			interval Between Onset and Death
/Med Exam		immediate Cause (Final disease or condition resulting in death) e. End Stage Dementu	9		years
	100	resulting in death) Due to (or as a consequence of):			
pen	rial-transit	b. ————————————————————————————————————			
O,	rial-tre	Sequentially list conditions, Due to (or as a consequence of): If any, leading to immediate causa. Enter Underlying			
68760, ficata be executed	tha burial-transit	causa. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of):			
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D B after a standard	etached for usa a	- Vi			
da.	detached	Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		./	ntribute to the cause of death?
ds, P	be deta	Aprtic Stenosis	_ 1	Yes 211 No	3 Probably 4 Unknown
B cords	should b			an autopsy	24b. Were autopsy tindings available prior to
	N E		-	oming:	completion of cause of death?
0	paga .		10	Yes 2 No	1 ☐ Yes 2 ☐ No
of Vital Physician: The	rector.		eath (Check only		
S to ry a sitti	funaral dire	1 Inpatient 2 EN/Outpatient 3 DOA 4 Nursing	Home 5 ☐ Rea 28d. Describe	how injury occurr	
4 0 # 4	ed in by the funers	1 Neturei 5 Pending (Month, Day Year) injury Work? 2 Accident investigation M 1 Yes 2 No			
10	15 th	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Numb wn, State)	er or Rural Routa Number,
विश्व है ।	ni bell		,		
A Pospital	completely filled	29a. Certiflier (Check only one) 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pie	ca, and due to the curred at tha fime,	cause(s) and ma date and placa,	nner as stated. and due to the cause(s)
Vithin Vithin To the	ald mo	one) and manner stated. 29b. Signatura and titla of cartifier 29c. License number		29d. Date signed	d (Month, Day, Year)
F 3 F	0	1 /2 lan 1.1.1	/	1	
V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		July	12 1175
1		Andres Salazar 711 maiden choicelane	atonsvi	Me, MI	1,20228
	State	31. Date filed (Month, Day, Year) JUL 1 3 1998 32. Registrum Storage Junion Rondon		,	
Re	gistrar	00 T T 0 1000			

State of Maryland / Department of Health and Mental Hygiene

one 98 21300

						Certifica	ale UI	Death		1	Reg. No.			
Diamet.		1. Decedant's Nam			05					2. Data of Dea		Vaar	3. Tim	e of Death
Physic /Med		Ja	nette	130	ir field					June 1		Yaar	5:1	.5 AM
Exami		4a. Facility Nama (I	lf not institution, g	iva street and number)				4b. City, To	wn, or Loc	cation of Death	4c. Count	y of Death		
		Harbor	Inn Con	valescent (Center			Balti	more		Balti	more	City	,
Funeral Director		5. Social Security N 217-20-		Sex 7. Age 1 □ M 2 □ F	93 (In yrs. last birt	hday) If Un Month	der 1 Yaar ns Days		24 Hrs. Min.	8. Data of Birt (Month, Da July 7	h y, Year) 1904		iace (Sta	ta or Foreig
D .		Usual Rasidance of Decedent												
filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or flems 23a or 28a-f show brt, the Med cal Examinet must be noticed at	tor	Maryland	10b. County Baltimo	ore City	10c. City, Town Balti							1		e City Limit ′as 2□ N
or 28	ire.	10a, Street and Nut	mber			10f.	Zip Code				10g. Citizan of	What Cour	itry?	
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State of Maryland / Department of Health and Mental Hygiene

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	-		23a. Party. Enter the disease, or co	mplications that caused	the death. Do n						t.		Approxim	ate
13	Physician		shock, or heart failure. List on	y one cause on each ir	10,								Interval Be Onset and	etween
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State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death 1. Decedent's Neme (First, Middle Last) 2. Dete of Deeth **Physician** BOWMAN /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) Examiner BALTIMORE HOSPITAL OF BALTIMORE If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)

Jan 20,1930 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** 1 M XXF 68 Director 251-50-4149 Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23s or 28a-f ahow traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 🏋 No Director MD. Baltimore **Baltimore** the 10e. Street end Number 10f. Zip Code 10g Citizen of What Country? 3101 Jeffrey Road 21207 Funeral IISA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 py Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondery (0-12) College (1-4or 5+) Hygiene. 12th Custodian City Gov't 17. Fether's Neme (First, Middle, Lest) permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Itam 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Meiden Surneme) Hezekiah Miller Estelle Miller 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ray Thomas Bowman (Husb) 3101 Jeffrey Road Baltimore, Md. 21207 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete X Buriel 2 ☐ Cremetion 3 ☐ Removal from State King Memorial Park 7/15/98 Randallstown, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Caple Funeral Service of Funeral Service Licensee 5502 Winner Avenue Baltimore, Md. 21215 Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Myocardial Infarction Immediate Cause (Finel diseese or condition resulting in death) Examiner thet the death certificate be executed pue Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Box 68760, physician Physician/Medical P.O. I Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 Hypertention 1 Yes 2 No 3 Probably 4 Unknown l signed l Records, Be Completed by 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? Diabetes Mellitus 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical exeminer? 28. Piece of Deeth (Check only one) 1 Yes 20 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phy within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral is 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1x Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) AS2402321MW9219 JULY 10, 1998 Wiederkehr M.D. AS2402321MW9219 JULY 10, 1998

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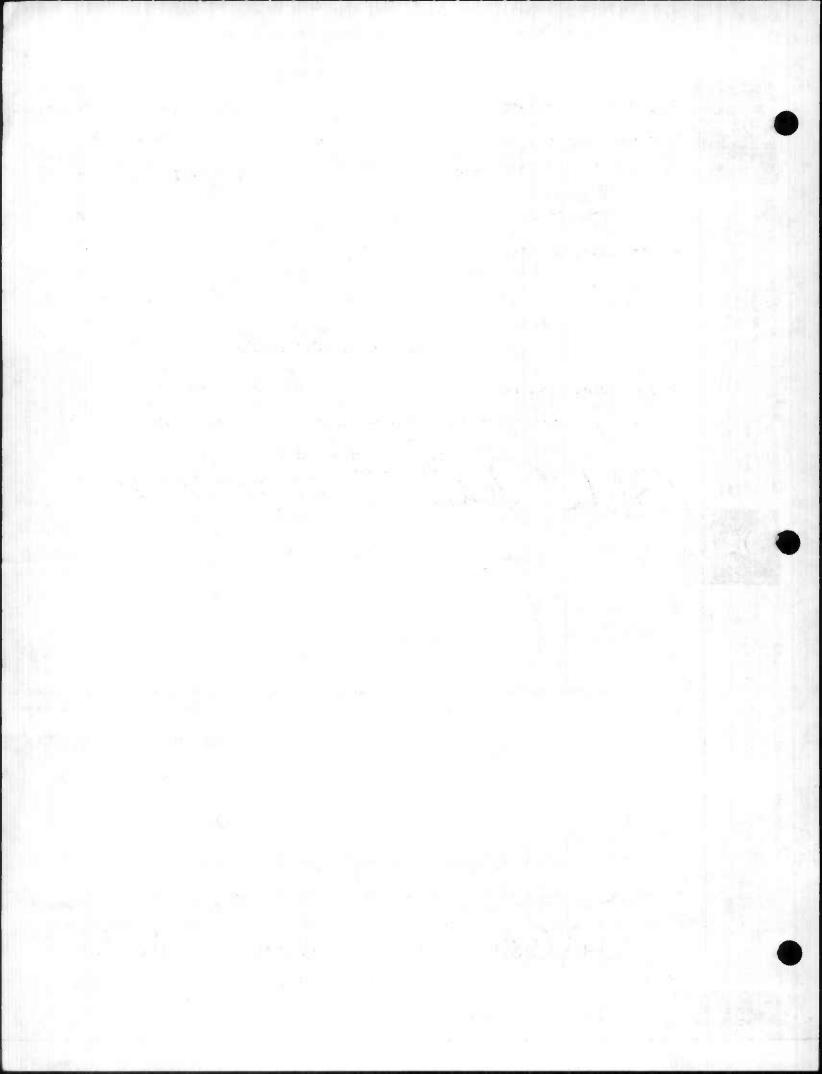
32. Fegietrer's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Yeer Margaret Baird Coppinger JULY 7, 1998 10:07 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Saint Joseph Medical Center Baltimore Towson If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Days 1□M %5FF 214-01-8850 Yrs. July, 9, 1912 New Jersey Usuei Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 229 Meadowvale Road 21093 United States Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bieck, White, atc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣☐ No If Yes, Give Year or Detes: 1 Never Married 2 Merried Specify: White 1 ☐ Yes 2 ☐ No Specify: XX Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Francis Xavier Baird Florence Margaret Hughes 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. C. M. Coppinger/son 229 Meadowvale ROAD Lutherville, MD 20b. Piece of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns07/09/98 Timonium, Maryland Coster 21. Signeture of Funeral, Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intervel Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting In deeth) RUPTURED ADRIIC ANEURYSM 3 DAYS Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence ot): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

important: If Item 27 any injury or other to

Department of

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be flied within 72 hours after nent of Health and Mental Hygiene.

altimore, Maryland 21215-0020

Box 68760,

P.O.

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Division of Vital

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Examiner Physician/Medical þ Completed page 2 Be Certification: To

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or Attending Physician: death. after deat Director: filled in by 24 hours a Hospital within 2

State Registrar

25. Wes case reterred to medical Hospitei: 1 Anpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 28a. Dete of injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturei 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a, Certifier (Check only one)

29c. License number 29b. Signeture end title of certifier

29d. Date signed (Month, Dev. Year)

m. D-

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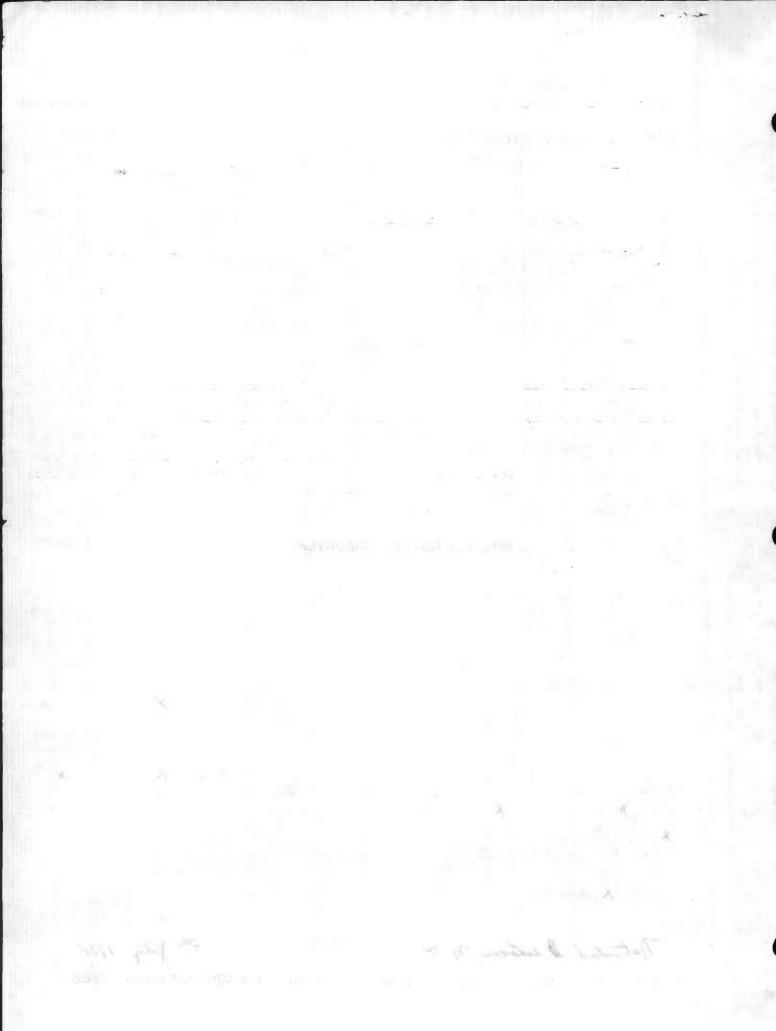
30. Name and address of person who completed cause of death (item 23a) (Type, Print)

7620 YORK ROAD, TOWSON, MARYLAND 21204 M. D. , NATIVIDAD D. DELEON,

31. Dete filed (Month, Day, Year)

JUL 1 3 1998

32. Registrer's Signeture whia Davidson-Randell



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of Ivia	iryianu / i	Certifica:		neann and N Death	nemai my	Reg. No. 98	2	1305
	Physici	an	1. Decedant's Name (First, Middle, Las	t)					2. Data of De Month	Day	Yaar	3. Time of Death
	Physici /Medic	al	Eugene Grayso		Cross				July 9			7:10 AM
Á	Examin	er	4a Facility Name (If not Institution, give					4b. City, Town, or L	ocation of Deat	th 4c. County	of Death	
	<u> </u>		16608 Briardale			lf I India	. 1 Vans	Derwood If Under 24 Hrs.			gome	and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th
	Funeral Director		215-07-5507	7. Age	(In yrs. last bii	Yrs. Months	Days	Hours Min.	8. Date of Bir (Month, Di Feb. 3,	rth ay, Year) , 1918	9. Birthpl	ece (State or Foreign try) Md.
	how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10	Od. Inside City Limits
	o Ma	cto	Md. Montgor	nery	Gaith	ersburg						1 ☐ Yas 2 🛣 No
	ith th	Dire	10e. Street and Number			10f. Zi	Code			10g. Citizen of V	/hat Coun	try?
	23a	100	22109 Creekview D					882			SA.	
altimore, Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show says figury or other traumatic event, the Madical Examples must be notified at pince.	by Funeral Director	11. Marital Status 1 □ Navar Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Armed Forces? 1 Armed Forces? 1 Yes, Give Year or Dates:	0	13. Was Dece If Yes, spe	cify Cub	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		- America k, White, d : Whi	etc.
0	2 hou	8	15. Decedent's Ed	ucetion		. Decedent's Usu	al Occup	pation	1.2	16b. Kind of Bu		
215	hin 7.	Be Completed	(Specify only highast grade Eiementary/Secondary (0-12)	de completed) College (1-4or 5-	b)	(Giva kind of will life. DO NOT u	ork done ise retire	during most of work d)	king			
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nd	al Hy othy	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middla	a, Maiden Sumem	Θ)	
yla	Ment Ment arke	2	John K.		Cross			Florence			Gr	ay
Jar	2 sh ls m ls m		19a. fnforment's Neme/Reletionship (7					and Number or Rui				
e,	f end feeith m 27 ther t	-	Mrs. Jennifer C. (20a. Method of Disposition	Graham/dau	ghter 2	22109 Cr	eekv	iew Dr. G	Baithers Data	sburg, Mo	i. 20	882
Jor	or of	- 1	1 ☑ Burial 2 ☐ Cremation 3 ☐		cemete	ry, crematory or	other pla					
ţ	rt Pe rtant:	-	4 Donation 5 Other (Specify)	Garris	son Fore		etrans 7	7/14/98	Owings I	Mills	, Md.
Ba	permit. Pege Department of Important: if any injury or pnce.		21. Schature Puneral Service Lice	500	-	Ruck	Tows	on Funera Rd. Towso				
0	Physician		23a. Part1. Enter the disease, or comp shock, or heert feilure. List only of	lications that caused one cause on each iin	the death. Do a.	not enter the mo	de of dyir	ng, such as cerdiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
di.	/Medical Examiner		Immadiate Causa (Final disease or condition resulting in deeth)	a. Conges	tive Fa	ilure						24 Hours
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Ć.	10 E	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying		ation 5	consequence of) -7%					i	
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Division of Vital Records,	been s	Completed b	Rheumatoid Arthr	itis						s an autopsy ormed?	ava coi	ere autopsy findings allable prior to mplation of cause death?
ď	The la	E							10	Yes 2 No	10	Yas 2 No
ā	rtifica ctor, p	Be	25. Wes case referred to medical					26. Place of Dea	th (Check only	one)		
>	Physici this ce	To	examiner? 1 ☐ Yes 2 ☑ No	Hospitai: 1 ☐ Inpatie	nt 2 ER/O	utpatient 3 D	OA Ott	ner: 4 Nursing He	ome 5□Res	idence 6 10th	er (Specify	Group Home
ouo	Attending Physician: or death. ector: After this certific by the funerel director,		27. Manner of Death 1 ☑ Neturei 5 ☐ Pending 2 ☐ Accident invastigetion	28a. Date of Injur (Month, Day		Time of Injury M	28c. Inju Wo 1 □	ryat rk? Yes 2 □ No	28d. Describe	how injury occur	ed	
Divis	after dea Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Inju building, etc		erm, street, facto	y, office		28f. Location City or To	(Street and Numb own, Stete)	er or Rura	l Route Number,
ł	To the Hospital or Attending Physician: The law within Zuhours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, pege 2	edical C	29e. Certifier (Check only one) 2 Medicat Exam	sician: To the best of fner: On the basis of and manner sta	examination ar	e, deeth occurred ad/or investigetion	l et the ti	me, date end piece, opinion, death occur	, end due to the rred et the time	cause(s) end me , date and place,	nner as st and due to	eted. the cause(s)
	o the	Me	29b. Signature and title of cofficer		1	25	c. Licens	e number		29d. Data signe	d (Month,	Day, Year)
	⊢ ≩ F ŏ		CHIM (1)	shippo	1	A	2443	3620		July 9,	1998	
	0 -11		30. Name and address of person who o	ompleted cause of de	ath (Item 23e)	1 633		7=7		, ,		
	201		John Y. Shigo, M.	D. 18540 (Office	Park Dr		Gaithers	burg, M	laryland	2087	9-2578
	Sta Registr	te ar	31. Dete filed (Month, Pay Year) 31	98 32. Registr	r's Signature	con-Randa	æ.					

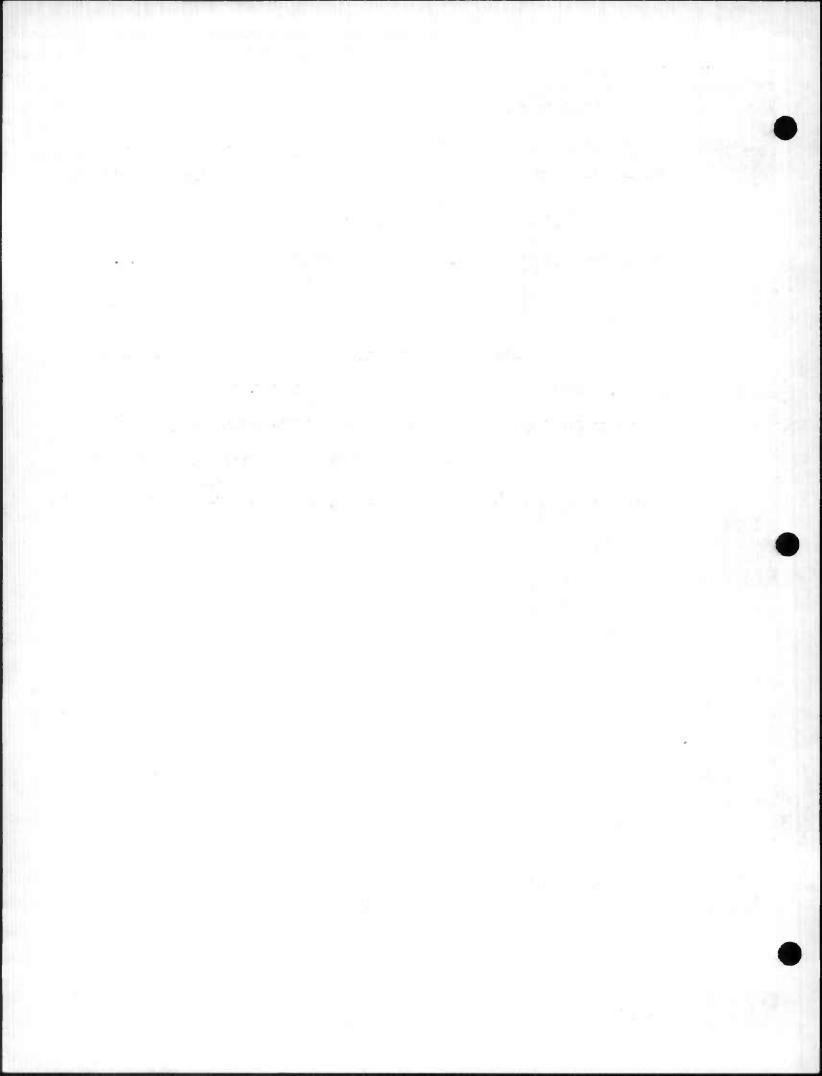
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State of Maryland / Department of Health and Mental Hygiene () Item: 31 per V.R. reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** AM BERNARD DUVALL CARTER ull /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner renera Ca lary and N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Sociel Security Number 6. Sex Birthplece (State or Foreign Country) **Funeral** Deys Hours 12XM 2□ F Director 212-28-2106-A 7/23/30 VIRGINIA 67 Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location r 28a-f show a notified at 10d. Inside City Limits the Man/ta Director 1 XYes 2 No MD N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8 must be therns 23a 1102 DRUID HILL AVENUE-APT. 210 21217 Funeral U.S. 12. Wes Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married ò 1 ☐ Yes 2 No Specify: by Specify: 3 Widowed 4 Divorced BLACK "natural". Completed the Medical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 Hygiens. Elementery/Secondery (0-12) College (1-4or 5+) 8 LABORER INDUSTRIAL 17. Fether's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Surneme) Pages 1 and 2 should be finant of Health and Mental I unt: If Nem 27 is merked of ALFRED N. CARTER MARY J. CARTER 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) important: if item 27 is any injury or other tree 8304 CHARMEL DRIVE-RANDALLSTOWN, MD EARL CARTER (BROTHER) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 7/14/98 LANSDOWNE, MARYLAND MOUNT ZION CEMETERY 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility REDD FUNERAL SERVICE muelle 1721-27 N. MONROE STREET-BALTIMORE, MD 21217 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Onset end Death **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner nonia physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Physician/Medicai Due to (or es e consequenca of): for use as P.O. P Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? the should be detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. þ 24b. Were eutopsy findings evaileble prior to Completed 24e. Wes en eutopsy periormed? completion of cause 1 Yes 2 No 1 Yes 2 No Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28e. Dete of Injury (Month, Dey Yeer) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) or A 4 Homicide To the Hospital within 24 hours To the Funeral completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted. Medical 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29b. Signature and title of oprtifier 29c. License number 29d. Date signed (Month, Day, Year) . D. М 30. Name and eddress of person who completed cause of death [ltern 23st] (Type, Print 31. Date filed (Month, Day, Year) 32. Registrer's Signeturé

JUL 1 3 1998 State Registrar

DHMH 16 Rev 6/95



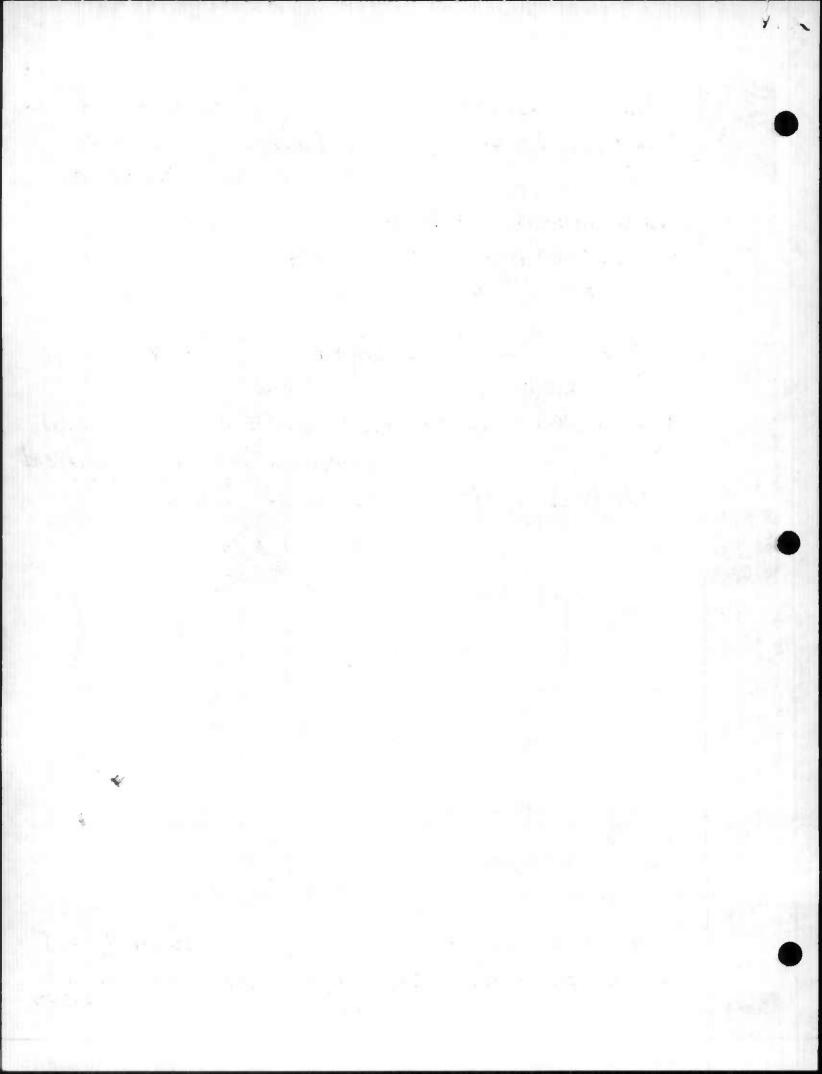
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State of Maryland / Department of Health and Mental Hygiene

21307 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULY :30 AM 1998 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ARKVII M Under 24 Hrs. 5. Social Security Number 6. Sex If Under 1 Yeer 7. Age (In yrs. last birthday) **Funeral** 9. Birthplaca (State or Foreign 1 M 2 1 F Days Hours 216-52-7160 Yrs Director Usuai Residenca of Decadent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f shoving must be notified at ltimore 1 ☐ Yes 2 🕱 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 881 21231 Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. treumatic event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours efter 1 Never Married 2 Married Yes 2 No Yes, Give Yeer or Dates: 21215-0020 ò Specity: White 1 ☐ Yes 2 No Specify 3 □ Widowed 4 □ Divorced "natural" 15. Decedent's Education 16a. Decadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. than Elamentary/Secondary (0-12) Collega (1-4or 5+) 12 yes Department of Heelth and Mental Hygis Important: If Item 27 is marked other any injury or other treumstic event, it Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Symame) Be 19a. Informant's Name/Relationship (Type, 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Baltmore, Md 216 husband Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 11 Surial 2 Cremation 3 Removal from Stete 4 Donation 5 □Other (Specify) 1998 Dulaney Valley Memorial Galden
22. Name and Address of Facility & IIMONIUM 21. Signature of Funaral Service Licensee Evans Chapel of Chimes ORK IIMONIUM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one causa on aach line. **Physician** /Medical Immediate Cause (Final ASPIRATION 2 HARS disease or condition resulting in death) Examiner Examiner SCLEROSU MYOMOPHIC Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Lest on or orrector: After this certificate hes been signed by the attending physical and filled in by the funeral director, page 2 should be deteched for use es the burielment Dua to (or as a consequenca of): The law requires that the death certificete be execu P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes No No 3 Probably 4 ☐ Unknown Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after deeth.

To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2: NA 1 🗆 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case ratarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Daath 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 2 Accident 5 Pending investigation 1 TYes 2 No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Julene 30. Name and addrass of person who complated cause of gaath (Itam 23a) (Type, Print) (NABNEY PARKVILLE MO 8900 WALTER ATTHEW BCVD 31. Date filed (Month, Day, Year) State Registrar

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	State of Maryland / Department of Health and M Certificate of Death	lental Hygie Reg.	90	21308
	1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
Physician	Judith Gravely deBuys	Month JULY	10 199	
/Medical Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	ocation of Death	4c. County of De	
Funeral	GREATER BALTIMORE MEDICAL CENTER TOWSON 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) fi Under 1 Year fi Under 24 Hrs. Months Days Hours Min.	8. Dete of Birth (Month, Day, Ye	BALTII	MORE Birthplace (State or Foreign Country)
Director	214-72-5245 80 Yrs.	April 3,	1918	PA.
B 2	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limite
the Marylar 28s-f show notified at	MD. Baltimore Lutherville			1 ☐ Yes 2 ☐ No
or 28a soull	10e. Street and Number 10f. Zip Code	10g	. Citizen of What	Country?
h with 33s or st be r	409 Brightwood Club Drive 21093		USA	
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	William E. deBuys, Jr. 1511 Don Gaspar, San			
Baltimore, semit. Pages 1 a bepartment of Nes mportant: If Item my Injury or othe IDSE.	20a. Method of Disposition 1 ☐ Buriat 2 ☑ Cremation 3 ☐ Removel from State		c. Location - City	
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Ball permit Depar Import any it	21. Signature of Funeral Service Licanseer 22. Name and Address of Facility Mitchell-Wiedefe 6500 York Road Ba			212
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Physician /Medical Examiner	Immediate Cause (Finel disease or condition HEART FAT COCK			Onset and Deeth
	Immediate Cause (Finel disease or condition resulting in death) a. HERET FAT CARCA Due to (or as a consequence of): SEVEN Due to (or as a consequence of):	K FRLMA	MARY	
8760, rate be executed thysician end the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause, Disease or Injury C.			
cate be exphysician exphysician exphysician experience	Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of):			
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cord require		24e. Wes an a performe		b. Were autopsy findings eveilable prior to completion of cause of deeth?
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f Vital Respectively.	25. Was case referred to medical 28. Place of Deat	h (Check only one)		
Of V hysici this ce rel direc	examiner? No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence	ce 6 Other (S	(pecify)
Affection:	27. Manner of Death 1 Death S Pending 28a. Date of Injury 28b. Time of Injury Work?	28d. Describe how	Injury occurred	
cat her	2 Accident Investigation M 1 Yes 2 No	Opt I and the Char	4	Out of Courts Manufact
200	28e. Place of fnjury - At home, ferm, street, factory, office building, etc. (Specify)	City or Town,		Rural Route Number,
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To the within 2 To the comple	29b. Signeture en li title of cartifier 29c. License number	290	Date signed (M	onth, Day, Year)
•	30. Narroy and address of person, who completed eaust of department 23e (1799e, Print) 526 200 E.	3×20 6	BAL	T. M. J.
CATA	31. Dete filled (Month, Day, Year) 32. Registran's Signature		-	
State Registrar	31. Dete filed (Month, Day, Year) 32. Registrar's Stonitum			

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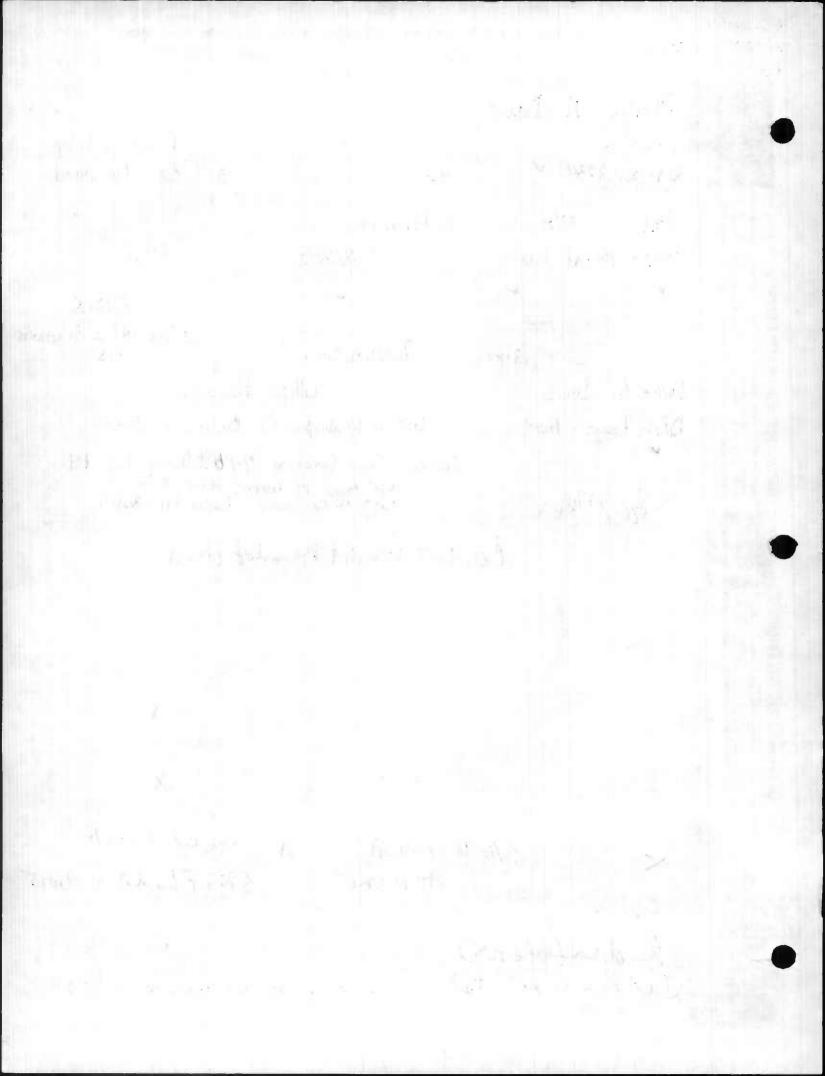
As Short Rivers Livings

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DAVIS PHILLIP A. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ASP Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey Month **Physician** 1998 4e Fecility Neme (If not institution, give street and number) JULY 12:40 A 11 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore AVE 5903 BLAND BALTIMORE H Under 1 Yeer If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. 8. Date of Birth (Month, Dey, Birthplece (Stete or Foreign Country), 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 219-52-273 150 M 2 F 46 Yrs. Director Maryland Usuel Residence of Decedent with the Maryland r 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 1d. 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number Examiner rount be 5903 3121 Funeral d 2 should be filed within 72 hours after death th and Mental Hygiena.
7 is marked other than "natural; or items 23 traumatic event, the Medical Estimation main 12. Wes Decedent Ever in U,S. Armed Forces? 1 Stres 2 □ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race -American Indien. 11. Maritel Stetus Bleck, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Black Baltimore, Maryland 21215-0020 Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Office Solutions Elementary/Secondary (0-12) College (1-4or 5+) echiaicer 2 yrs. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Lillian Wille recurson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itsm 27 is m any injury or other traum once. Belto, Md. 21229 Hunt 1015 N. Woodington Lewis 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Buriel 2 Cremetion 3 Removel from State 298 Owings Hall Cemeteru 4 ☐ Donetion 5 ☐ Other (Specify) torest 22. Name and Address of Fecility & Services 21. Sanittwe of Funeral Service Licensee Home funeral Belto M - 21213 Ille Broodway 1639 N. 23a Part Viright the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, of hear feilure. List only one cause on each line. Approximate fntervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Fine) disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed attanding physician and for use as the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of) SB signed by the a 23b. Did tobacco usa contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f 20 No 3 Probably 4 Unknown 1 Yes by 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 2 1 ☐ Yes 2 ☐ No certificata Physician: director, 25. Wes cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Pis 28e. Dete of Injury
(Month, Dey Ye) uneral 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred hieid Amending 1 Neturel 5 Pending 1 Yes death. 2 Accident investigetion 6 Could not be determined 28f. Location (City or Tor 3 Suicide 28e. Plece of Injury - At hon building, etc. (Specific (Street end Number or Rurel Route Number At home, ferm, street, factory, office 4 Promicide 報 Home 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dele end pleca, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. 29e. Certifier Medical 38 within 2 To the 8 29b. Sim re and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 11,1998 O.C.M.E JULY pleted cause of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 36. Begistra's Signeture

State Registrar



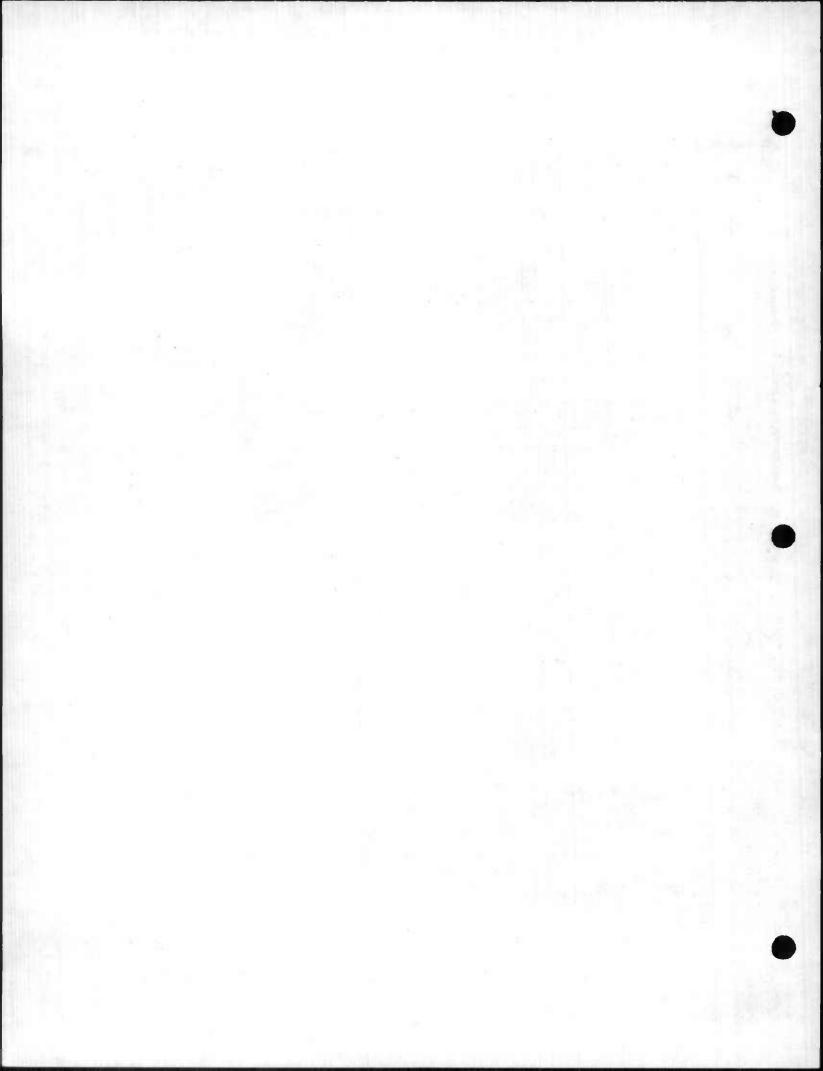
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day **Physician** Daniel John Dubiel 9, 1998 9:20am July /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** 631 Harvey Street Baltimore City ff Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1€1M 2□ F 215-28-3300 Yes Director 66 August 8, 1931 Maryland Usual Residence of Decedent the Maryland r 28a-f show Inotified at 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A NOWes 2 No MD Baltimore City Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code iner must be n 631 Harvey Street 21230 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status XX Yas 2 No Army If Yas, Giva Yaar or Datas: 52-54 hours after 1 Nevar Married Married Baltimore, Maryland 21215-0020 8 White 1 Yas ≥ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry 72 filed within Elementary/Secondary (0-12) College (1-4or 5+) 6th Grade N/A Steel Worker Manufacturing 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Be Pages 1 and 2 should be nent of Health and Mental Louis John Dubiel Magdaline Ludwig 19a. Informant's Name/Ratationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routs Number, City or Town, State, Zip Code) . nt of Health a if them 27 is or other time 631 Harvey Street, Baltimore Maryland 21230 Joan D. Dubiel / Wife 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Oate 20c. Location - City or Town, Stata cematary, cramatory or other place) 128urial 2 Cramation 3 Ramoval from Stata Department of Important: If any injury or Sacred Heart of Jesus Cemetery July 13, 1998 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Nama and Addrass of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore, Maryland 21230 23a. Part1. Entar tha disaasa, or complications that caused the death shock, or haart failura. List only one ceusa on each line. Do not enter the mode of dying, such es cardiec or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Finet Hypercalcenua

Due to (or as a consequence of): disaasa or condition rasulting in death) Examiner Examiner Kenal Cell Carcinoma Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated events rasulting in daath) Last Due to (or as a consequence of) Physician/Medical Dua to (or as a consequence of): Box The law requires that the death certi USB P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 certificate 1 Yes YNO 1 ☐ Yes 2 ☐ No of Vital Physician: 8 25. Was casa referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa XX Residence 6 Other (Specify) 1 Yas XXNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Deeth 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? After Division or Attending XXNatural 5 Panding s after death. 1 ☐ Yes 2 ☐ No Invastigetion 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicida Hospital 24 hours edical 29a, Cartifian XXX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the P 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signatura and titta of certifier 13-10529 July 10, 1998 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) 22 South Green Street, Baltimore Maryland 21230 Heather Mannuel, MD 31. Date filed (Month, Dey, Year) 32. Registrar's Signatura State Felia Tavidson Pandage

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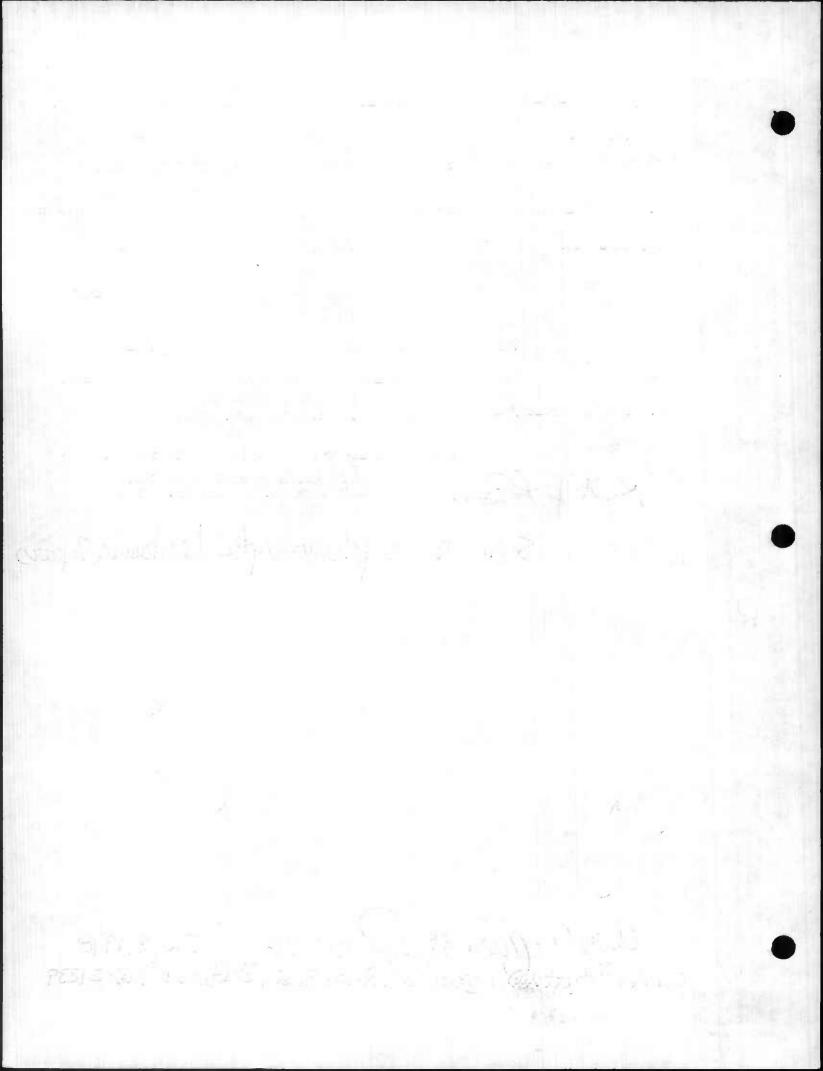
Registrar



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death July **Physician** William . 1998 Ehrlich Gerd 1:00PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 600 Stacy Ct. Baltimore If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 22 1922 7. Age (In yrs. last birthday) 559-24-2946 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F 76 Germany Yrs. **Director** Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at MD. Baltimore Towson 1 ☐ Yes 2 No Director 10f. Zio Code 10e. Street and Number 10g. Citizen of What Country? 600 Stacy Ct. 21286 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hyspens. 1 Yes 2 No If Yes, Give Year or Datas: 1 ☐ Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be (7 is marked of traumatic evi-Hugo Ehrlich Gertrude Stern 2 19e. Informant's Name/Relationship (Type, Print)
Mrs. Sibylle Ehrlich/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) or other tra 600 Stacy Ct. Towson, MD. 21286 20b. Placa of Disposition (Name of 20a, Mathod of Disposition Date 20c. Location - City or Town, Stata cematery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If any injury or 7-9-98 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. Towson, MD. 21. Signetura of Funaral Sarvice Licensaa 22. Name and Address of Fedlity Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23a. Part1. Enter the disease, or admplications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or es e consequenca of): The lew requires that the death certificate be associated Box 68760. Physician/Medical Dua to (or as a consequence of) 88 signed by the attendin d be detached for use P.0. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Completed by Division of Vital Records, 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? should **page 2** has 1 Yes 2 2 No. 1 ☐ Yea 2 ☐ No certificate or Attending Physician: funeral director, Be 25. Was case referred to medical axaminer? 26. Placa of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 8 Other (Specify) this 27. Manner of Deeth 28b. Tima of 28d. Describe how injury occurred 28a. Deta of Injury (Month, Day Year) 28c. fnjury at Work? Affer 5 Pending investigation 1 DRatural To the Hospital or Attending within 24 hours after deeth. To the Funeral Director; Afti completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of fnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier IX Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, death occurred et the time, date end placa, and dua to the cause(s) and manner stated. 29b. Signature and the of certifie 29d. Data signed (Month, Day, Year) k. Licanse number m 30. Name and address of passon who completed cause. Raven Blud rada arles 32. Registrar's Signature State Lulia Davidson Registrar

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State of Maryland / Department of Health and Mental Hygiene 8 2 3 2

Certificate of Death

Reg. No.

Physician					OG.	unica	te of L	Jealii		Re	g. No.		
	1. Decedent's Nem		Joseph	Alfre	od Car	ogo I				2. Dete of Death		398	3. Time of Dec 9:00 F
/Medical Examiner	4e Facility Neme (iger	4	b. City. To	wn, or Loc	ation of Death	4c. County	of Death	imore
uneral rector	5. Social Security N		Sex XOM 2□F	7. Age (In yrs. 97	last birthday) Yrs.	lf Unde Months	r 1 Yeer Deys	If Under	24 Hrs. Min.	8. Dete of Birth (Month, Dey,	Year) 1900	9. Birthp Cour Nev	place (State or Fo
	Usuel Residence o	f Decedent											
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to 286-1 s. be notified Director	10e. Street and Nu	mber				10f. Zi	p Code	-		10	Og. Citizen of 1	What Cour	ntry?
nathe ral Di	1	92 Loin						566				SA	
Examiner must Examiner must	3 Widowed	ied 2 Merried	12. Wes Dece Armed For 1 Tes If Yes, Give Yeer or De	ces? 2[XNo		Wes Dece If Yes, spe	cify Cuba	n, Mexican	gin? (Spec , Puerto F	cify Yes or No- tican, etc.)		ck, White,	en indian, etc. nite
event, the Medical. Be Completed	(Spec	15. Decedent's E cify only highest gr	ade completed)		(Give	dent's Usu kind of wo DO NOT L	ork done o	during most	of workin	9	16b. Kind of B	usiness/In	dustry
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		ohn Gan						TO. INIOCITO		zabeth			
r is marked or traumatic eve To Be	19a. Informant's N	eme/Reletionship	Type, Print)		19b. Meili	ing Addres	s (Street	end Numbe	or Or Rural	Route Number,	City or Town,	State, Zip	Code)
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month C. Giordano Mary July 8, 6:45 AM 1998 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death Genesis Eldercare Center Cromwell Parkville Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Yeer Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 6 Sex 1 □ M 2 🔀 F Months Days Yrs 91 216-10-5886 June 10, 1907 Baltimore, MD Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1210 Dulaney Valley Road 21286 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 XNo Specify: 3 ¼ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Years Seamstress Tailoring 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Josephine Sabatino Joseph Brocato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph Rallo /Son-In-Law 1210 Dulaney Valley Road Towson, Maryland 21286 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, Stete 1₺ Buriai 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery July 10,1998 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. Wallack S. Broads, Dr. - 1050 York Road Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Is chemic Heart disease Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 48 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

eny le

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumetic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health end Mental Hygiene. Important: if flear 27 is marked other than "natural", or items 23 eny Injury or other traumatic event, an islandical Emerine must

altimore, Maryland 21215-0020

with the Maryland

Examiner Physiclan/Medical þ Completed Be

as USB 2 funeral Certification:

attending physician Division of Vital Records, P.O. Box 68760 signed to has certificate Hospital or Attending Physician: After this s after death. filled in by

24 hours completaly within 2

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

1 Yes 2 No

27. Menner of Deeth

1 Natural

2 Accident

3 ☐ Sulcide

29a. Certifier

4 | Homicide

(Check only one)

29b. Signature and title of cartifier ach Kardlast

5 Pending

investigation

6 Could not be determined

28a. Date of Injury (Month, Dey Year)

47813 Palkway

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29c. License number

28c. Injury at Work?

1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

1 Yes 2 No

Ballinde MD

28d. Describe how Injury occurred

29d. Dete signed (Month, Day, Year) 1998

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

KARAKISH BASHAR 3007 ENOUNE

32. Registrer's Signeture

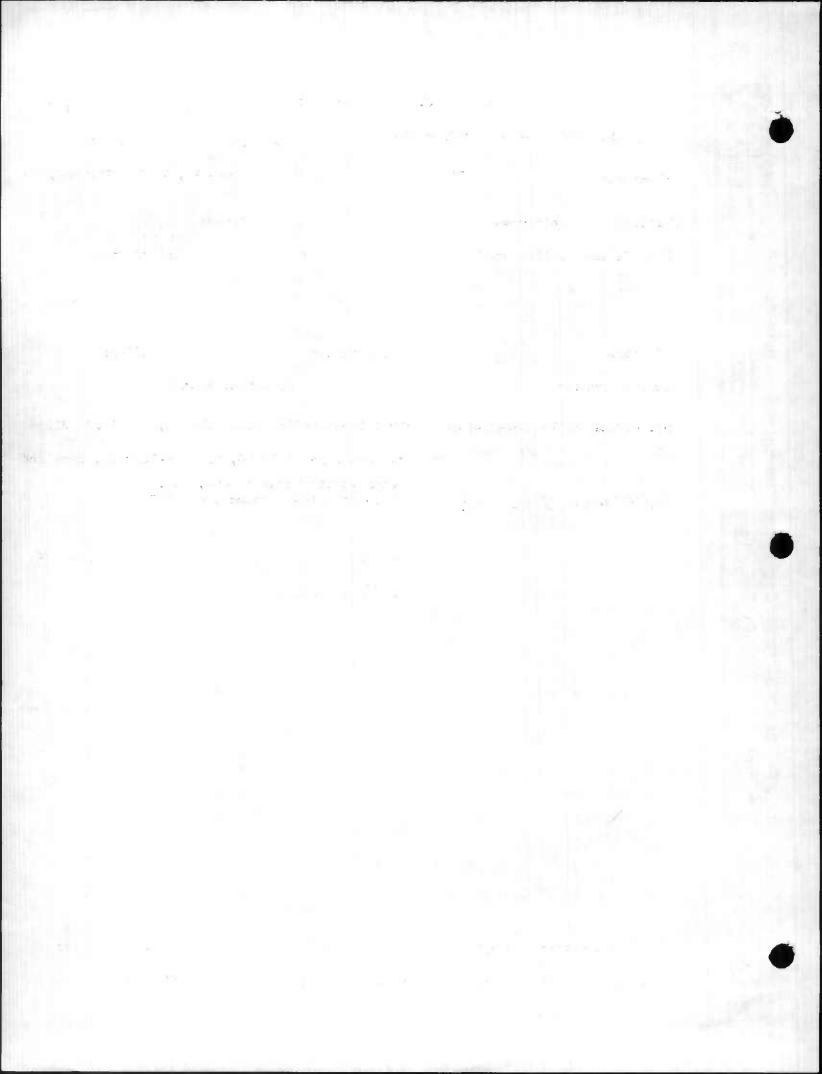
31. Date filed (Month, Day, Year) JUL 1 3 1998

Julie Davidson-Randelle

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar



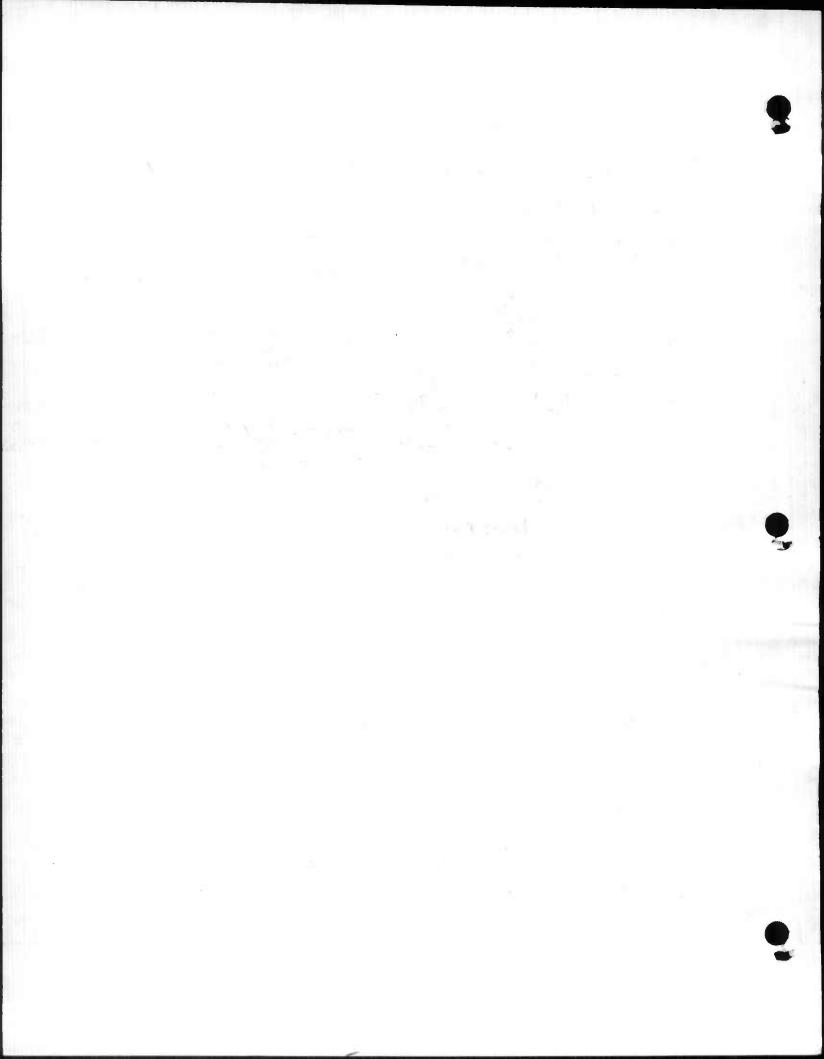
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98 2/3/4 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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	Elizabet	th (= room	7						7			1998	10	PM
	4. SOCIAL SECURITY NUMBE		5. SEX	6. AGE (In	yrs. last birthday) YRS.			F UNDER 2	MIN.	7. DATE O	F BIRTH Day, Year)	9	Countr	PLACE (State or F y) SOUri	oreign
	9a. FACILITY NAME (If not inst		treet and number)			9b. CITY, TO	WN OR	LOCATIO	N OF DEA		2 0		INTY OF D		
DINECTOR	Johns Hopkin			riatr	ic	Balti							/A		
3		10b. COUNTY				TY, TOWN OR L	OCATIO	N						10d. INSIDE CIT	Υ
5	MD.	Baltir	more		Ва	ldwin								LIMITS?	NO
FUNERAL	10e. STREET AND NUMBER 2744 Glen E	lvn Wa	av					O13					USA	VHAT COUNTRY?	
	11. MARITAL STATUS 1 Never Married 2 N	Aarried	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 XNO	If ye	DECEN	IDENT OF		, Puerto Ri	(Specify Yea can, etc.)		14. RACE	E — American Ind	len,
5	3 🖺 Widowed 4 🗌 Divorc	bed												White	
3	15. DECE (Specify only	DENT'S EDU	CATION completed)		16a. DECEDENT'	work done during			7	16b. I	KIND OF BUS	SINESS/IN	DUSTRY		
Committee E	Elementary/Secondary (0-1	12)	College (1-4 or 5	+)	Nurs	use retired.)					Healt!	hcar	e		
5	17. FATHER'S NAME (First, Mid	idle, Last)						IB. MOTH	ER'S NAM	AE (First, Mi	iddle, Maiden	Surname)			
	Sidney S. S.	toaks						Al	ice	Edmo	ndson				
	19a. INFORMANT'S NAME (7)	oe/Print)			19b. MAILIN	G ADDRESS (St	reet and	Number	or Rural A	oute Numbe	er, City or Tow	n, State, Z	ip Code)		
2	Hall Kellogg	(so	on)		2744	Glen	Ely	n Wa	У,	Bald	win, I	MD.	210	L3	
	20e. METHOD OF DISPOSITION 1 Description 5 Other (3 Rem	oval from State		PLACE AND DATE					7/6/	20c. LO		City or To		
	21. SIGNATURE DE FUNERAL		ENSEDennis	_						1 .				eral Hon	ne. T
	· 1)0	^ '	C. (/ /	nall				Rd.		Towson			21204	, 1
CERTIFICATION	ahock, or he IMMEDIATE CAUSE (Fine disease or condition resulting in death) Sequentially liet condition if any, leading to immed cause. Enter UNDERLY! CAUSE (Disease or injur that initiated eventa resulting in death) LAST	ona, llete NG	b. STR	OKE ORASA	ATTIGA CONSEQUENCE	0F): 0F):	me	262,	ITU.	5				Interval E Onset an FD Type 14 y	
	PART II. Other algolificar	nt condition	na contributing to	deeth bu	t not resulting	In the unde	rlying	cause g	iven in	Part I.	24e. WAS AN PERFOR	RMED?	246	AWILABLE PRIOR COMPLETION OF OF DEATH?	CAUSE
	DID TOBACCO US	SE CONT	RIBUTE TO CA	AUSE OF	DEATH Y	ES NO	N	UNC	ERTAIN	10				1 TYES 2	
	25. WAS CASE REFERRED TO				6. PLACE OF DE			-							
	EXAMINER?		HOSPITAL:	☐ ER/Outpe	tient 3 DOA	QTHER:	Home	5 🗆 Res	sidence	6 Other	(Specify)				
		Pending	28e. DATE Of (Month, I	F INJURY Day, Year)	26b, Ti	ME OF 28	c. INJUI	RY AT			CRIBE HOW I	NJURY O	CCURED		
	3 Suicide 6 C	could not be	26e. PLACE (OF INJURY -	— At home, ferm			3 2	, NO	261. LOCA City o	TION (Street or Town, State)	end Numb	er or Rural	Route Number,	
			ICIAN: To the best of											and menner es	stated.
	29b. SIGNATURE AND TITLE						-		NSE NUM						
	Muchy	14	1. An	lor 1	ND		,	DZ	163	360		290.0/	7/0	5/199	18
	30. NAME AND ADDRESS OF	A A	O COMPLETED CAL	MD DEA	TH (ITEM 27) (Ty)	HOPKIN	SE	BAYI	new	CIRC	ie Br	ITIN	nee N	10 217	74
	31. DATE FILED (Month, Day, Y	31998	32. REGISTR	AR'S SIGNA	TURE Ran							// 4	72.6		
لــ	4444		- 4-												



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 2 2 1 2

		,	Certificate of Death	Reg. No.	21313
	Discription.	Decedant's Nama (First, Middla, Last)	1	2. Data of Deeth Month Day Yes	3. Time of Death
	Physician /Medical	CHARLES THOMAS	GUYTON	JUNE 23,1990	B 11:35 Am
	Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or L	ocation of Deeth 4c. County of De	eath
		NORTH ARUNDEL HOSPIT		XENIE AA.CO	UNTY
	Funeral Director	5. Social Sacurity Number 220-12-5058 Usual Rasidanca of Decedant 6. Sax 1 M 2 F 7. Age (In yrs. last 72	t birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Year)	Birthplaca (Stata or Foreign Country) aryland
	Mend wo	10a. Stete 10b. County 10c. City, T	own or Location		10d. Inside City Limits
	Meny Hr sh	Maryland Anne Arundel Gler	n Burnie		1 ☐ Yas 2 € No
	vith the Me or 28a-f s be northed	10e. Street and Number	10f. Zip Coda	10g. Citizan of What	Country?
	th with	206 Spring Maiden Court	21060	U.S.A.	
21215-0020	s 1 and 2 should be filed within 72 hours efter death with the Meryland I Health and Mental Hygiene. tem 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinet must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Navar Marriad 2 Marriad 3 Widowed 4 Divorced 12. Was Decedant Evar In U,S. Armed Forces? 1 Yes 3 No If Yes 3 No If Yes 3 No Year or Datas: WWII	13. Was Decedant of Hispanic Origin? (Spif Yas, specify Cuban, Mexican, Puarto 1 ☐ Yes 2√√2 No Specify:	pecify Yes or No- o Rican, atc.) 14. Race - A Black, W Specify: 7	merican Indian, Thite, atc. White
2-0	ed within 72 hor ygiene. or than "netura rt, the Medical Completed	15. Decedant's Education (Specify only highast grada complated)	16a. Decedant's Usuel Occupation (Give kind of work done during most of work	16b. Kind of Busine	ass/Industry
121	within than "	Eiameqiary/Secondery (0-12) Collega (1-4or 5+) Unknown Unknown	(Giva kind of work done during most of work life. DO NOT usa ratired) Truck Driver	Furnitu	re
	Hygiene. Hygiene. om, the			na (First, Middle, Maidan Sumama)	
and	ntai H ed out			Ruth Gates	
Maryland	end Mentai end Mentai a marked o aumatic eve		19b. Mailing Address (Street and Number or Ru.		re, Zip Code)
N	end 2 seatth er n 27 la	unknown	unknown		
Baltimore,	00-		a of Disposition (Nama of atary, cramatory or other place)	Date 20c. Location - City	or Town, Stata
Balti	permit. Page Department of Important: If any Injury or phos.	21. Signatura of Funaral Sarvica Lican and Sant	²² State Anatomy Boa Baltimore, Maryla		nore Street
	Physician	23a. Part T. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not anter the mode of dying, such as cardiac	or raspiratory arrast,	Approximata intarvel Between Onset end Daeth
?	/Medical Examiner	rasuling in daath)	CANDIOMYONATI s a conseguence of):	14	24ems
	executed in end ial-trensit	CONGESTA	R JEANT FAILU s a consequence of):	32	1 week
68760,	rificate be executed g physician end as the bunal-trensit	Ceuse (Disease or Injury that inlitieted evants	FAILU1E se consequence of):		1 week
Box 68		rasulting in death) Last	MELLITIS		syears
	deeth cer e ettendir d for use	Pert ii. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part t.	23b. Did tobacco uss contrib	oute to the cause of death?
s, P.O	The iaw requires that the deeth certiste has been signed by the ettending page 2 should be detached for use a Completed by Physician/M			1 Yss 2 No 3	Probably 4 Unknown
Records,	been signature should t			24a. Was an autopsy performed?	4b. Wera autopsy findings available prior to
ecc	has be				completion of cause of death?
R	ysician: The law requin s certificate has been s director, page 2 should To Be Completed			1 ☐ Yas 2 ☑ No	1 Yas 20 No
Vital	certificate rector, pag	25. Wes case referred to medical axeminar?		ath (Check only one)	
of				loma 5 ☐ Rasidanca 6 ☐ Other (5	Specify)
NO.	After this funeral d	1 Natural 5 Panding (Month, Day Year)	Bb. Tima of Injury at Work? M 1 Yas 2 No	28d. Dascribe how injury occurred	
Division	Attender death ector: by the	2 Accidant invastigation 3 Suicida 6 Could not be 4 Homicida 28e. Pieca of Injury - At home building, atc. (Specify)		28f. Location (Street end Number of City or Town, Steta)	or Rurel Routa Number,
	To the Neeptal or Attending Physician 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	29a. Certifiar (Check only one) 1. ☐ Certifying Physician: To the best of my knowle 2. ☐ Medical Examiner: On the best of axamination and manner stated.	idge, death occurred at tha tima, deta end plece a and/or invastigetion, in my opinion, deeth occu	, and dua to tha causa(s) and manna rred at tha time, data and pleca, and	ar as stated. due to tha cause(s)
	within To the compl	29b. Signature and title of certifies I an # Schulled	Lem 29c. Licansa number 2822	29d. Date signed (M	
_		30. Name and address of person who completed cause of deeth (frem 2:	3e) (Type, Print) NONTH ARUN.	DEL MOSPITA	a C
	State	31. Data filed (Month, Day, Year) 32. Registrer's Signatur	e		

Registrar



Water St. None of the St.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

CHARLES

State of Maryland / Department of Health and Mental Hygiene

10f. Zip Code

ificate of Death		Reg. No.	
	2. Date of De		
	Month	Dey	

	GII	L	
		Physi /Med Exam	dical
	F	unera irecto	al or
21215-0020	d within 72 hours after death with the Maryland	perio. In than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed by Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a any Injury or other traumatic event, the Medical Examiner must once.

Physician

/Medical

Examiner

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After

e Hospital or Attanding n 24 hours efter death. te Funeral Director; Afte

To the Vithin 2

8

Examiner

Physician/Medical

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Completed

2

Certification:

edicai

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records,

Attending Physician;

Funeral

ò

Completed

Charles Edward Gill. Jr. 4a Facility Name (If not Institution, give street and number)

JULY 4b. City, Town, or Location of Death 10, 1998 12:06P.M. 4c. County of Death

3. Time of Death

155 OCEAN PARKWAY 5. Social Security Number 220-88-6399

1. Decedent's Name (First, Middle, Last)

OCEAN PINES ff Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. last birthday) 1 XM 2□ F Months Days Hours 32 Yrs.

WORCESTER 8. Date of Birth Year Oct. 9, 1965 Maryland 9. Birthplace (State or Foreign

Usual Residence of Decedent 10a. State 10b. County Md.

10c. City, Town or Location Carroll Hampstead 10d. Inside City Limits 1X Yes 2 □ No

10e. Street and Number

1411 North Main St. 3A

21074 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10g. Citizen of What Country? U.S.A.

1 Never Married 2 Married

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ﷺ No If Yes, Give Year or Dates:

College (1-4or 5+)

1 ☐ Yes 2 ☐ No Specify:

 Race - American Indian, Black, White, etc. Specify: White

3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)

18a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Bartender

16b. Kind of Business/Industry Restaurant

17. Father's Name (First, Middle, Last)

Elementery/Secondery (0-12)

Charles Edward Gill

18. Mother's Name (First, Middle, Meiden Sumeme) Patsy Ann Howard

19e. Informent's Name/Relationship (Type, Print)

Patsy Gill - Mother

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1411 North Main St. 3A, Hampstead, Md. 21074

20a. Method of Disposition 1 ☐ Guriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place) Date Evergreen Mem. Gardens July 14,1998 Finksburg,

20c. Location - City or Town, State Md.

22. Name and Address of Facility Eckhardt Funeral Chapel

23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiretory arrest,

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate Approximate interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting In deeth)

a Contact gunshot wound of head Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury

Due to (or as a consequence of)

that initiated events resulting in death) Last

	1	Yes	

26. Place of Deeth (Check only one)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2⊠No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Limited 1Æ Yes 2□ No 1 No 2 No

25. Was case referred to medical examiner? 1 X Yes 2 □ No

27. Manner of Death

1 Netural

2 Accident

3 Suicide

28a. Date of Injury (Month, Dey Year)

7-10-98

Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

1206

Other: 4 Nursing Home 5 Residence 6 Other (Specify) SHED 28c. Injury at Work? 1 Yes 2. No

28d. Describe how injury occurred self inflicted gunshot wound 281. Location (Street and Number or Aural Route Number, City or Town, State) 155 Ocean Parkway

6 Could not be determined 4 Homicide 29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Shed Workester County, Many 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examinar: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Maryland

(Check only one) 29b. Signature and title of certifier

29c. License number O.C.M.E. 29d. Date signed (Month, Dey, Year) JULY 11,1998

30. Name and address of person who completed cause of death (Item 26) (Type, Print)

Radentz 111 Penn Street, Baltimore, Maryland 21201 MP

State Registrar Stephen S.
31. Date filed (Month, Day, Year) JUL 1 3 1998

5 Pending

investigation

32. Registrer's Signature Mandale

. . E n.E-M Tidaki II. the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s Baldade 27 (40) of the consultation, a some of W. A. J. Dorger and J. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. M. St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market St. Market S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#7 per FH G761 7/13/98 EW Reg. No. 2. Date of Death 3. Time of Diseth 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:48 p.m 07 98 05 Darnell /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death Examiner University Of Maryland Hospital Baltimore If Undar 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2€F Months Days 49 48 Oct.12,1948 Virginia 219-50-1298 Usual Residence of Deceden Director 10c. City, Town or Location 10a State 10b. County 10d. Insida City Limits r 28a-1 show 1 ☐ Yes 2 No Directo N/A Essex Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? r than "naturel", or items 23a or 21221 U.S.A. 783 Seawall Road permit. Pages 1 and 2 should be filed within 72 hours after death via population of Health and Mental Hygiene. Important if them 27 is marked other than "neturel", or thems 23, any injury or other transmitter event, the Medical Exemples mans Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indien, Black, White, atc. 1 Naver Married 2 Married 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) 12th Home Maker Home 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Be Taylor Fannie Willard Carey Sr. 19b. Malling Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cynthia MacCall-Sister 2310 Winchester Street Balto.Md. 21216 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7-6-98 Catonsville, Md. 4 Donation 5 Other (Specify) Metro Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Nancy M. Wallace Funeral 3405 W.Franklin Street.Balto.Md.21229 a, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. u Approximata Interval Batween Onsat and Death Physician /Medical Immediate Causa (Final disease or condition resulting In death) Examiner Dua to (or as a consequence of) Examiner Sequantially list conditions, if any, leading to immadiate causa. Entar Underlying Causa (Disaasa or Injury Due to (or as a consequence of) Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? 1 Yes 2 No 3 Probably Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 20 No 1 Yas 2 No 25. Was case rafarred to medical examiner? Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Lo 1 Impatient 2 ER/Outpetlent 3 DOA 27. Mannar of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Certification: 1 Watural 2 Accident 5 Pending Invastigation 1 ☐ Yes 2 ☐ No 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida

Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29c. Licanse number

844176 435 mg 184

29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760 physician s the burial requires that the death certificate be 88 use Use signed by the a certificate has t irector, page 2 s or Attending Physicien: this funeral Affer death. after deat Director: filled in by hours a Hospital 24 hours

with the Maryland

Baltimore, Maryland 21215-0020

To the Hosp within 24 ho To the Fune completely fi

edical

29a. Certifier

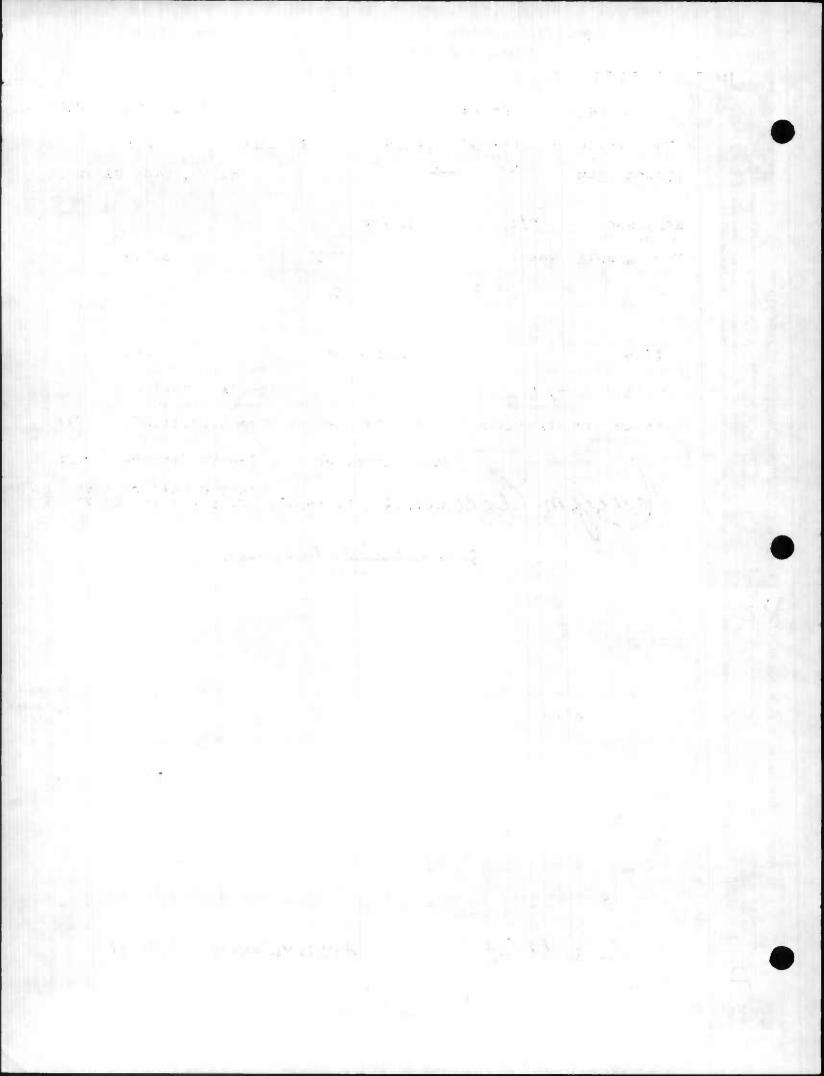
(Check only one)

29b. Signature and title of certified

State Registrar 30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print)

UnivERsity

of MEHTA MARYLAND 32. Registra Signature UL 1 3 1998 Mr Davidson Randall



Certificate of Death Rea. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath 3. Time of Death **Physician** ANDREW HUGHES 2:27 A.M 1998 Juli 08 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** Rosedae If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Center HOSPITA Age (In yrs. last birthday) Saluare Baltimore tranklin If Undar 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1₩ 2□ F Months Days 220-14-1926 73 JULY 26,1924 MARYLAND Director Usual Rasidance of Decedant filed within 72 hours after death with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits other traumatic avent, the Madical Examiner must be notified at 1 Yes 2√ No Director MD. BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6 1907 WILLS ROAD 234 21222 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? XYYas 2 □ No IYas, Giva Yaar or Datas: ¶45 — ¶47 14. Race - American Indian, Itams Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 11. Marital Status Black, Whita, etc. 1 ☐ Nevar Married 2 ☐ Married permit. Peges 1 end 2 should be filed within 72 hours at Department of Health end Mentel Hygiene. Introortant: If Item 27 Is merked other than "natural", or any Injury or other traumatic avent, the Mentel once. ò 1 ☐ Yas 2 XNo Specify: þ 3 Widowed 4 Wivorced WHITE Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry ANDREW Elementary/Secondary (0-12) Collaga (1-4or 5+) TRUCK DRIVER GENERAL FREIGHT 18. Mothar's Nama (First, Middle, Malden Sumama) 17. Father's Nama (First, Middla, Last) WILLIAM HUGHES CAROLINE BARBARA BANDY 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) CHERYL WISNER/DAUGHTER 2013 HUNTFIELD COURT FALLSTON, MARYLAND 21047 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other p 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE WASHINGTON 7/13/98LAUREL MD. 20707 CREMATORY 1 22. Nama and Addrass of Fecility 21. Signature of Funeral Service Licenses 21224 CHARLES S. ZEILER & SON, INC. 23a. Part1. Entry e diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Interval Between Onsat and Daath **Physician** Immediate Causa (Final disease or condition resulting in death) Infarction /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiate ceusa. Entar Undarlying Causa (Disaasa or injury P.O. Box 68760 that initiated events rasulting in death) Last Dua to (or as a consaquance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yee 2 ☒ No 3 Probably 4 Unknown Division of Vital Records, ģ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarred to medicel axaminar? Be 26. Placa of Daath (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) L_o 1 ☐ Yas 2 🔀 No 2 ER/Outpatient 3 DOA 1 🖾 Inpatient After this funerel 28d. Describe how injury occurred 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: or Attanding 5 Panding invastigation 1 Natural s after death. 1 Yas 2 No 2 Accident 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Cartifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) manner stated. (Check only one)

29d. Date signed (Month, Day, Year)

9000 Franklin Square Drive Baltimore, MD 21237

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

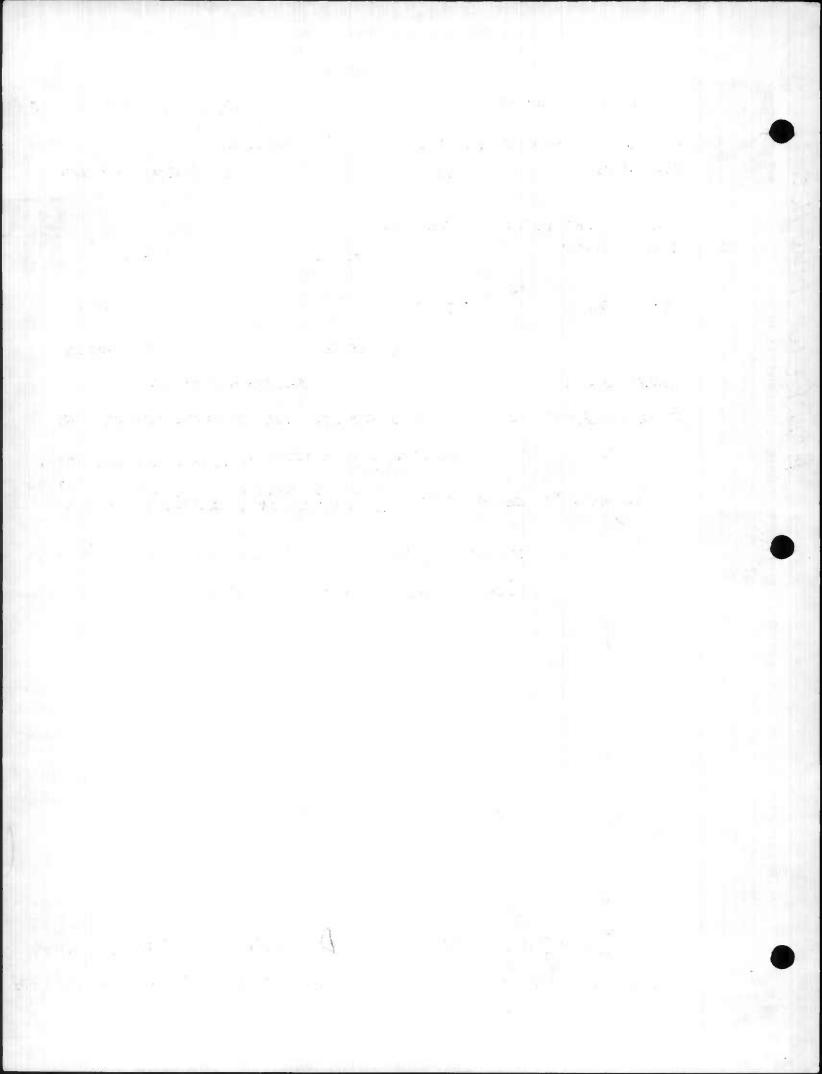
State Registrar 29b. Signetura applittie of certifier

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13199832. Registrar's Signatury Javidson

30. Nama and addrass of parson was complated causa of death (Itam 23a) (Type, Print)

ZAMORA



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** DOROTHY MABEL HUTCHINS JULY 7. 1998 6:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 18, 1930 Birthplaca (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 67 Director Md. 217-26-1712 Usuel Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits mat be notified at 1 ☐ Yes 2 🖾 No Director Md. Baltimore Towson 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Norna 23a 950 Radcliffe Rd. 21204 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 2∑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Sielus the Medical Examiner Black, White, etc. 72 hours after 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 MNo Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry flied within 7 Hygiene. other than "n Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mertal Hygien Important: If them 27 is marked other the any Injury or other treumetic event Home maker Own home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be To Louis Rick Lillian Jones 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Charles W. Hutchins, Jr./son 302 Waterview Ct. Hampstead, Md. 21074 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial 7/10/98 Timonium, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21 Signature of Funeral Servi 1050 York Rd. Towson, Md. 21204 23a: Part1. Enter the disease, or complicelions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** POSSIBLE MYOCARDIAL INFARCTION Immediate Cause (Final disease or condition resulting in deeth) /Medical 1 HOUR Examiner Due to (or as a consequence of) Examiner GRAM NEGATIVE SEPSIS 5 DAYS Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initialed events resulting in death) Last physician and Due to (or es a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical Due to (or as a consequence of): USB P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy lindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? has 1 Yes 2 No 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical examiner? Be director 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this After thi funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? or Attanding 1- Natural 5 Pending death. 1 Tes 2 No investigation n 24 hours after death e Funeral Director: A pletely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide within 24 hour 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner sleled. 29a. Certifier edical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 48271 -ah

State Registrar

31. Date filed (Month, Day, Year)
JUL 131998

FAHED KOULI, M.D.

7600 OSLER DRIVE, S-201 TOWSON, MARYLAND 21204
32 Projetrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 998 2100 JULY /Medical 4a Facility Nama (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospitar ANDALLSTOWN NONTHWEST Armone CENTER 8. Date of Birth (Month, Day, Dec. 8 If Under 1 Yaar If Undar 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days 1**⅓**M 2□ F Months Hours Min Yrs. 91 1906 215-09-8181 Maryland Director Usual Residence of Decedent with the Maryland 10e State 10b. County 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "naturel", or frams 23a or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Randallstown Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9009 Lesan Road 21133 U.S.A. permit. Fages 1 and 2 should be filed within 72 hours after death vice and the permit of Health and Mental Hygiena. Important if Item 27 is marked other than "naturel", or flams 23, any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Race - American Indian. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo White Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1942-45 Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) College (1-4or 5+) Elamentary/Secondary (0-12) Clerk Unknown 18 Mother's Name (First Middle Maiden Sumeme. 17. Father's Name (First, Middla, Last) Sabra Elizabeth Gibb John Francis Houston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) unknown unknown 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph B. ²² Nama and Addrass of Facility State Anatomy Board, 655 W. Baltimore Street Van Sant Baltimore, Maryland 21201 23a Part Enter the diseasa of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Physician /Medical Immediata Cause (Final disease or condition resulting in death) Examiner requires that the death certificate be axecuted physician and the burial-transit Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 98 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the s should be detached 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? The law r page 2 has 1 Yas 2 No 1 Yas 2 Who certificate or Attending Physician: director, 25. Was casa referred to medical axaminer? Be 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 2 1 hpatlent 2 ER/Outpatient After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Mannar of Death 28c. Injury at Work? Certification: 5 Panding Investigation 1 Natural Z Accident after death. 1 ☐ Yas 2 ☐ No 6 Could not be datarmined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier edicai 29c. Licensa number 29d. Date signed (Month, Dey, Year)

State Registrar

31. Date filed (Month, Day, Year) 131998

29b. Signature and title of curillie

Clo NONTHWEST 32. Registrar's Signature

465PITAL

pieted cause of death (Item 23a) (Type, Print)

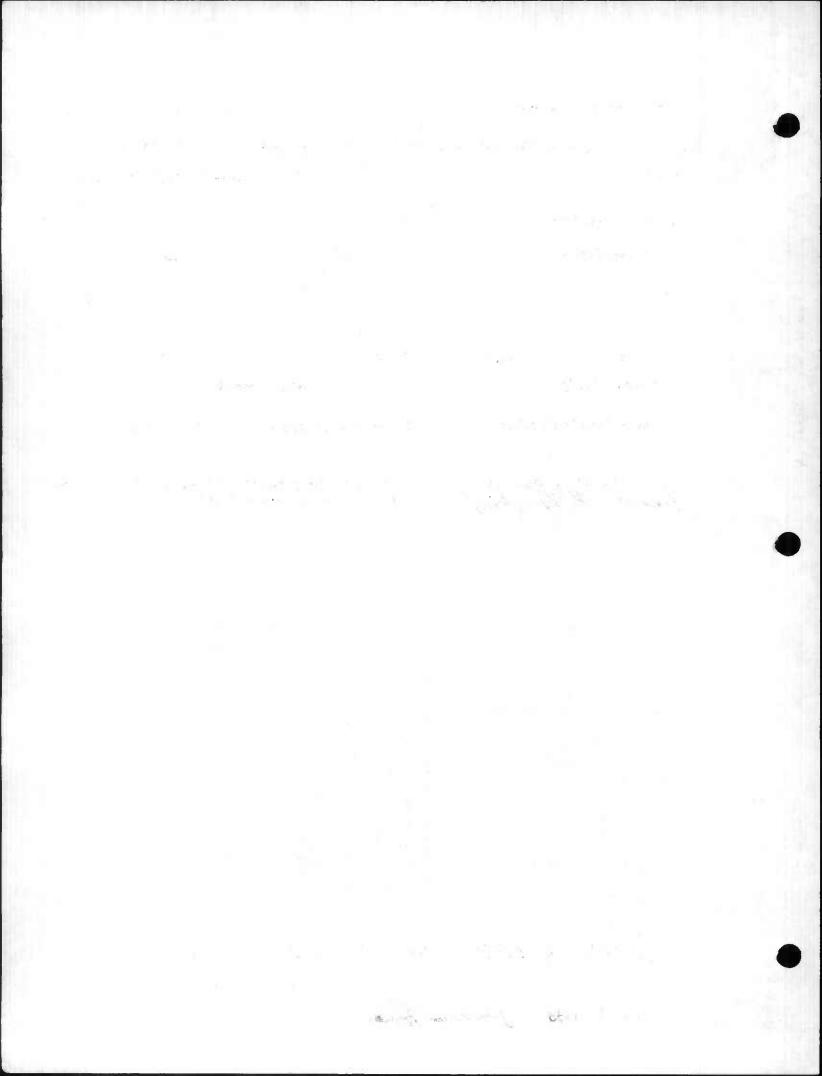
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Funeral Director		5. Social Security Number 6. Sex none 12M		last birthday) Yrs.	If Under 1 Year Months Deys	Roseda If Under 24 Hrs. Hours Min. 10	8. Dete of Birth (Month, Dey,	Year)	9. Birthplece (Country) Maryla	State or Foreign
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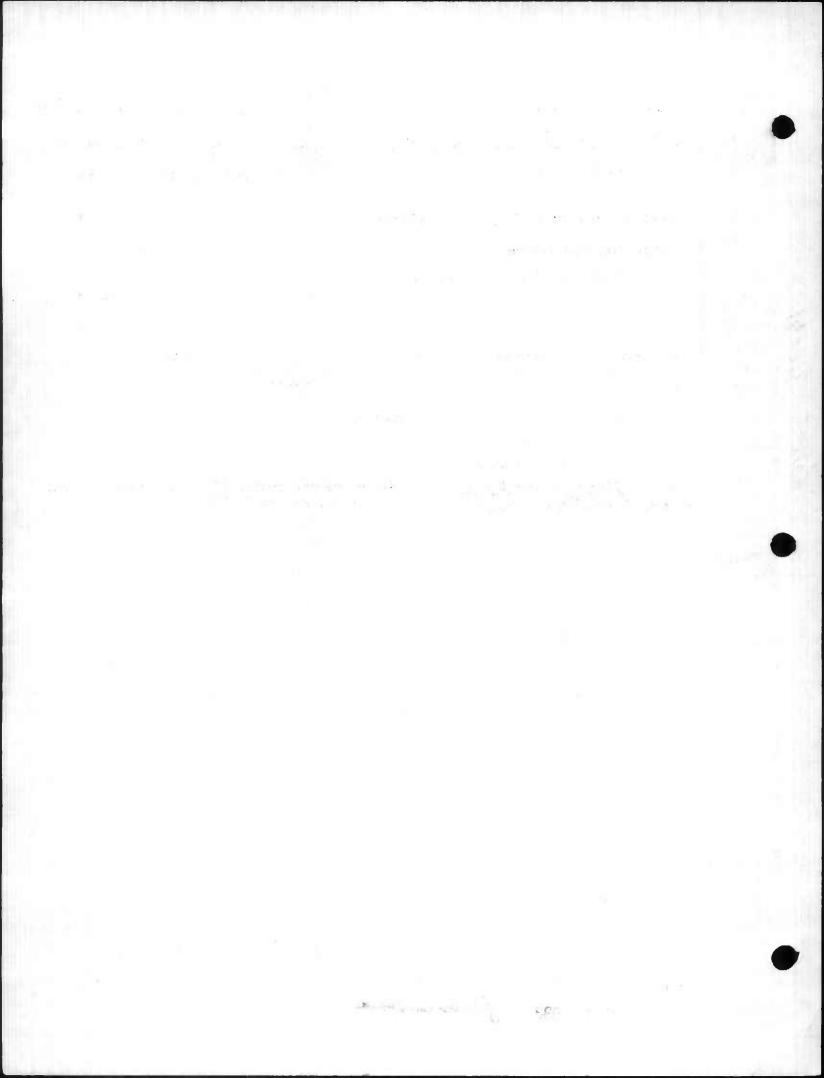
Hardy, Tymere



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State of Maryland / Department of Health and Mental Hygiene

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Examiner			eneral H	spite	1/	LACON DO	Baltim	or Location of Deal	В	altim		
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net: If i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	b. Place of Discountery, o	sposition (A trematory o	lame of r other plan	oe)	Date	20c. Location	City or To	wn, State	
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		Part II. Other significant conditions con	tributing to death but not	resulting in the	e underlying	g cause giv	un in Part I.		tobacco use co Yes 2□ No	atribute to 3 ☐ Prob		Unknor
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s certificate has director, page 2 To Be Comp		25. Was case referred to medical examiner?					26. Place of D	eath (Check only	one)	11000	1000	94.00011
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Attenta funera tion:		27. Manyer of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28s. Date of Injury (Month, Day Yes	r) 28b. Time Injur		28c. Injur Wor	yat k? Yes 2□No	28d. Describe	how injury occur	red		
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Me omp		29b. Signature and title of certifier	100.000.000.000.000.000.000.000.000.000		2	9c. Licens	e number		29d. Dete signe	d (Month, I	Dey, Year)	
s F 0		► \\\\.	1125			80	7274		4/30,	48		
	1	Name end addrass of person who co	er, M.D.	Item 23a) (Typ	e, Print)	Ryll	and Gr	enera	e Hoi	SPT	tal	7
State Registrar	1	31. Dete filed (Month, Day, Year)	32. Registrar's 9	SURUS - V	Pandall	•						



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		State of	of Marylar		partmen <i>ertificat</i>			and N	fental Hyg	20	3 2	1323
Decedent's Name (Fire	it, Middla, La	st)			Or imout	.	Dodin		2. Date of Dea	leg. No.		3. Time of Death
Dorothy	Mae	Jone	S						Month July	O7,	Yaar 98	11:55am
4a. Facility Nama (If not i	nstitution, giv	a street and nu	m <i>ber)</i>				4b. City, To	wn, or Lo	ocation of Death	-	inty of Deat	
Mariner	Healt	h Care	-Overe	ela			Balt	imo	re	N	IA	
5. Social Security Number		ex □ M 2□ <u>√</u> F	7. Aga (In yrs. 62	last birthda Yrs	Months	1 Yaar Days	If Under Hours	24 Hrs. Min.	8. Data of Birth (Month, Day 07-1	7. Year) 2-35	Co	hplaca (Stata or Foreign untry) MD
Usual Rasidanca of Dace												
7.7	County			ty, Town or								10d. Inside City Limits
Md	NA		Ba	altin	nore							Yas 2□No
10e. Street and Number					10f. Zip	Coda				10g. Citizan	of What Co	untry?
6116 Bel	air R	oad			21	206	5			USA		
11. Marital Status 1 □ Navar Marriad 2 3 □ Widowed 4 □ □		12. Was Dec Armed Fo 1 ☐ Yes If Yas, Gi Yaar or D	2 X No	I,S. 1			dispanic Ori an, Maxicar Spacify:	gin? (Sp , Puerto	ecify Yas or No- Rican, atc.)		Black, White	ncan Indian, a, atc. lack
15. E	ecedant's Ec	lucation de complatad)		16a. De	cedant's Usua	ai Occup	oation	t of work	£	16b. Kind o	f Businass/	Industry
Elemantary/Secondary 8th Grac		Collega (1-4or 5+)		va kind of wo. DO NOT us emplo			r or work	ing	Labo	rer	
17. Fathar's Nama (First,	Middla, Last)						18. Mothe	r's Nam	a (First, Middla,	Maidan Sun	nama)	
Handson		Gri	ffin				Ann	ie		Tho	mas	
19a. Informant's Name/R	alationship (Type, Print)		19b. Ma	iling Addrass	(Straal	and Numbe	er or Rur	al Routa Numbe	r, City or To	wn, Stata, 2	(ip Code) 21224
Elizabet	n Jone	es							Baltim			
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cra 4 ☐ Donation 5 ☐ 0	mation 3 🗆		Stata V C	Placa of Dis comatary, c	sposition (Nan ramatory or o	na of thar pla	ce)		Data 07-11-	20c. Locatio	on - City or	
21. Signatura of Funarai	Sarvica Lican	Sea			22. Nama an			, B				and 21202
23a. Part1. Entar tha dis- shock, or heart failu	aase, or com	cations that on a	aused tha daat ach lina.	h. Do not	antar tha mod	a of dyl	ng, such as	cardiac		rast,		Approximata Intarval Between Onset and Daath
Immediata Causa (Final disaasa or condition resulting in daath)		A51	DIRI	411	00	/	ONG	EU	MON	114		5 DAYS
			Dua to (d	or as a con	saquenca of):							
Sequentially list conditlor if any, laading to immadia causa. Entar Undarlying Causa (Disaasa or Injury	is,	0.	Dua to (d	or as a con	saquanca of):							
that initiated avants rasulting in daath) Last	1	0.	Dua to (o	or as a cons	equence of):							
		d										

Physician /Medical Examiner

The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunel-transit

certificate has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Completed

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Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental hygiene.
Important: If learn 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modesal Experiment matt be nothing any injury or other traumatic event, the Modesal Experiment matt be nothing as

Baltimore, Maryland 21215-0020

Director

Funeral

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Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last

Part II. Other significant condi

1 Yes 2 40 3 Probably 4 Unknown

TIPLE SCLEROSIN

24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed?

1 ☐ Yas 2 ☐ No

25. Was casa rafarred to medical axaminer?

26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)

28d. Dascribe how injury occurred

27. Mannar of Daath 1 Natural

2 Accidant

4 Homicida

3 Suicida

28a. Data of Injury (Month, Day Year) 5 Panding investigation 6 Could not be datarmined

Hospital:

28c. Injury at Work? 28b. Tima of

1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

25 No

29a. Cartifiar (Check only one)

to Cornifying Physican: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title

1 Inpatiant 2 ER/Outpatient 3 DOA

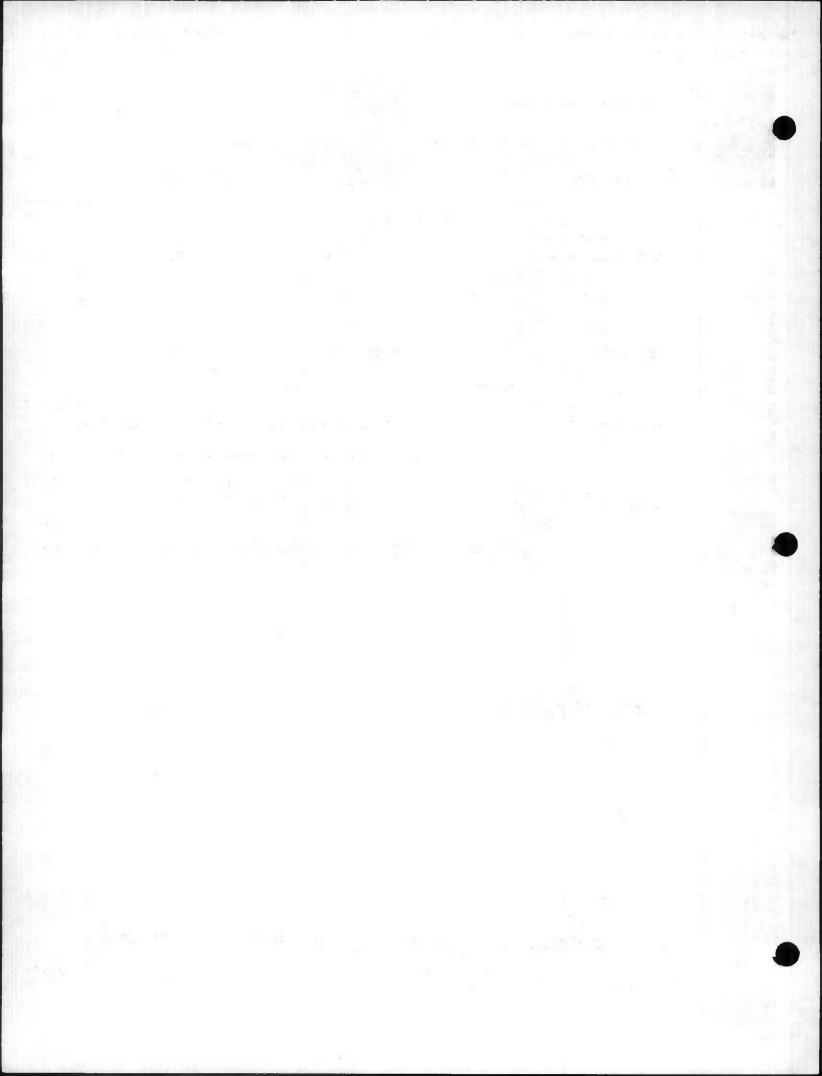
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

29d. Date signed (Month/Day, Year)

State Registrar 31. Data filed (Month, Day, Year)
JUL 1 31998

32 Registrar's Signatura was Davidson

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death 6:44 AM MOZUHOE PEAN JULY 10 1998 4b. Rity, Town, or Location of Daath 4a. Facility Nama (If not institution, giva straat and nymbar) 4c. County of Deeth Darvieu 6. Sax 7. Age (In yrs. last birthday) if Undar 1 Yaar 5. Social Sacurity Number 8. Data of Birth (Month, Day, 9. Birthptaca (Stata or Foreign Days 16-345 1 M 2 □ F Months Hours Usual Rasidanca of Decadant 10a. Stata 10b. County 10c. City. Town or Location 10d. insida City Limits 1 ☐ Yas 2 No 10e. Straet and Number 10f. Zip Coda 10g. Citizan of What Country? 12. Was Decadant Evar in U,S. Armed Forcas? 1 2 Yas 2 ☐ No Was Decedant of Hispanic Origin? (Spacify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritat Status 14. Raca - Amarican Indian, Black, Whita, atc., 1 Navar Married 2 Marriad 1 Yas 20 No Spacify: Yas Giva Specify: White 3 ☐ Widowed 4 ☑ Divorcad Yaer or Datas: 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) 10 17. Father's Neme (First, Middle, Lest) 18. Mothar's Name (First, Middle, Maidan Sumama) 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 20b. Ptaca of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata July 1 Buriai 2 ☐ Cramation 3 ☐ Ramovat from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funarai Sarviga Licensee 22. Nama and Addrass of Facility 0/25 23a. Part1. Enter the disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each tine. Approximata Intarval Batween end Death Immediete Ceusa (Finat 124 Bower OBSTRUCTEON disaasa or condition rasulting in daath) Dua to (or as a consequence of): YEML CANCER ZZIATEMB M LUNG Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or injury that initiated evants rasulting in death) Last Dua to (or as a consaquance of): Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performad? 20 No 1 Yas 1 ☐ Yas 2 ☐ No 25. Wes casa referred to medical axaminer? 26. Placa of Death (Check only one) Other: 4 Nursing Homa 1 Yas 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 5 ☐ Rasidance 8 ☐ Othar (Specify) 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

show

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or Items 23a or

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al Hygiene.

Mental is marked o other traumatic

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permit. Pege Depertment of Important: If any injury or

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event, the Medical Examiner must be notified at

Funeral Director

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Peges 1 end 2 should be filed within 72 hours effer deeth with the Maryland

Baltimore, Maryland 21215-0020

Box 68760.

P.0.

Division of Vital Records.

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours efter death.

Funeral Director: After this certificate has been signed by the ettending physician end burial-transit ettending physician been signed by the e should be deteched f Certification: filled in by the

Physician/Medical

Completed by

Be

2

Medical

1 Naturet

2 Accident

3 Suicida

29a. Cartifiar

4 - Homicida

To the Hospital within 24 hours e To the Funeral D

29b. Signatura and title of certific

31. Date filed (Month, Day, Year)

JUL 137998

5 Pending invastigation

6 Could not be datarminad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No 28d. Dascribe how Injury occurred

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

JULY

MD

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29c. Licansa number

29d. Data signad (Month, Day, Year) 1998

Location (Straat and Number or Rural Route Number, City or Town, Stata)

Neme end addrass of person who completed cause of deeth (Itam 23a) (Type, Print)

32. Registre Signatur hia Davidson

State Registrar



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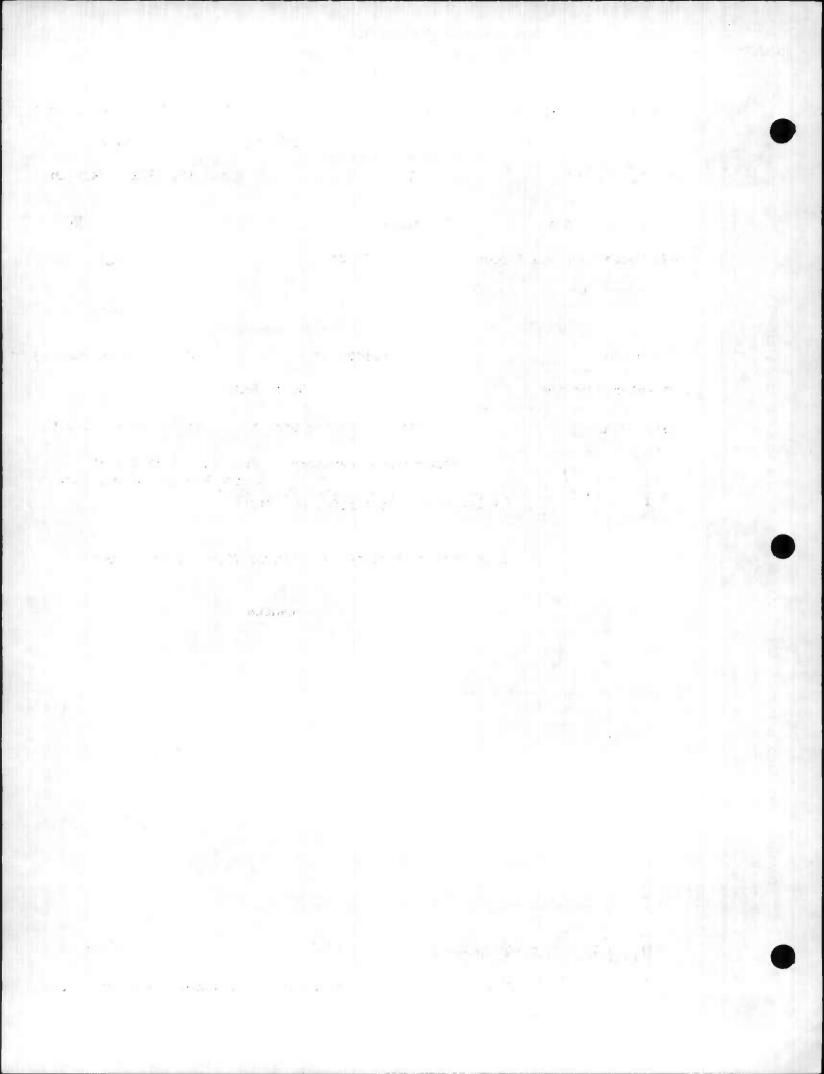
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GLADYS JONES	State of Maryland / Department of Health and Mental Hygiene

ASP	Decedent's Name (First, Middle, Last	1	Certificate of	Death	Re-	g. No.	3. Time of Deeth		
Physiçian /Medical	Gladys Sel	ena Jones			Month JULY	05 1	Year 998 2:50 A		
Examiner Funeral Director	442 N. ROBINS 5. Social Security Number 212-32-9774	ON ST.		4b. City, Town, or Lo BALTIMOR If Under 24 Hrs. Hours Min.		4c. County of Year) 3, 1931	n/a 9. Birthplace (State or Foreign Country) Maryland		
pue \$	Usual Residenca of Decedent 10a. State 10b. County		own or Location				10d. Inside City Limits		
death with the Maryland me 23a or 28a-f ahow creatibe notified at	M D n/a		imore				1 yes 2 No		
or 28s	10e. Street end Number		10f. Zip Code		10	g. Citizen of W	hat Country?		
ath wi	442 North Robinso		21224				USA		
urs after	3 ☐ Widowed 4 ☐ Divorcad	12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (X)No if Yes, Give Year or Dates:	13. Wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🟋 No		ecity Yes or No- Rican, etc.)		American Indien, k, White, etc. Black		
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in yiellu K.I.K. should be filed within to Mentel Hygiene. marked other than imatic event, tha M. To Be Comp			Caretake	_	e (First, Middle, M		aven Nursing H		
Mal yially d 2 should be file th and Mental Hy 7 is marked oth traumatic event	Cleveland Perkins			Sally A	she				
2 2 2 2	19a. Informent's Neme/Relationship (T)	rpe, Print) SON	19b. Malling Address (Street	t end Number or Rur	al Route Number,	City or Town,	Stete, Zip Code)		
of Heal	Raymond Ashe 20e. Method of Disposition 1 X Burlal 2 Cremetion 3 DF	20b. Plac	537 N. Bental e of Disposition (Neme of etery, cremetory or other ple			timore, Oc. Location - (MD 21216 City or Town, Stete		
Baltimore, permit. Pages 1 a Department of Hee Important: If Hem any Injury or othe	4 Donetico 5 Other (Specify) 21. Signature of Funeral Service Licens	Weste	22. Name and Address 2501 Gwyn Baltimore	ess of Fecility Nunns Falls	Pkwy		e, MD omes, Inc.		
PA COO. Physician Wedical Examiner The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The burief-transit The bur	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse, (Disease or injury	Due to (or as	ve Arterioscl s a consequence of): s e consequence of):	erotic Ca	rdiovasc	ular Di	Sease		
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aw requires to been so a should be should bleted					24a. Wes en INSPEC	CI'ION	24b. Were autopsy findings evailable prior to completion of cause of deeth?		
vital H defen: The certificate h rector, page	25. Was case referred to medical			00 Disse -4 Disse	1 Ye		1 ☐ Yes 2 ☐ No		
OT VITAL Physician: This certificate ral director, ps. TO Be Co.	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpetient 3□ DOA Ot	hor	th (Check only one one 5 12 Resider		er (Specify)		
Division of Vital Reform to the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate he completaly filled in by the funeral director, page Medical Certification: To Be Com									
DIVISION C tal or Attanding P rs ahar death. al Director: After t led in by the funera Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office		28f. Location (Str. City or Town,		er or Rural Roule Number,		
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To the within 2 To the comple	29b. Signature and title of cartified	elkule	29c. Licen	•M.E			5 , 1998		
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Registrar

JUL 1 3 1998

Julia Davidson Randalle



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State of Maryland / Department of Health and Mental Hygiene.

			Olato of Mai	•	Certificate of			leg. No.9 8	21326			
m	Dhusisian	Decedent's Neme (First, Middle, La	st)				2. Date of Dea Month	th Day	3. Time of Death			
	Physician /Medical	CHARLES			KENNE	Υ	JULY		1998 1:45 PM			
	Examiner	4e Facility Neme (If not institution, giv				4b. City, Town, or I	ocation of Death	4c. County	of Death			
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	Funeral Director	5. Sociel Security Number 6. S 190-07-5546	ex 7. Age (☑ M 2 ☐ F	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 29		Birthplace (State or Foreign Country) PA			
П	D R	Usuel Residence of Decedent 10a. Stete 10b. County	1	IOc. City, Town o	r Location				10d. Inside City Limits			
	with the Maydand a or 28a-f show be notified at Director	MD Baltim	lore	Towson					1 ☐ Yes 2 ☑No			
	or 28a4 a be notified Director	10e. Street and Number		20,001	10f. Zip Code			10g. Citizen of V	What Country?			
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68760,	physician s the buria	Cause (Diseese or injury that initieted events resulting In death) Last	C	ie to (or es e cor	sequence of):							
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	within 2 comple	29b. Signeture end title of certifier		<u> </u>	29c. Licens	se number		29d. Date signe	d (Month, Day, Year)			
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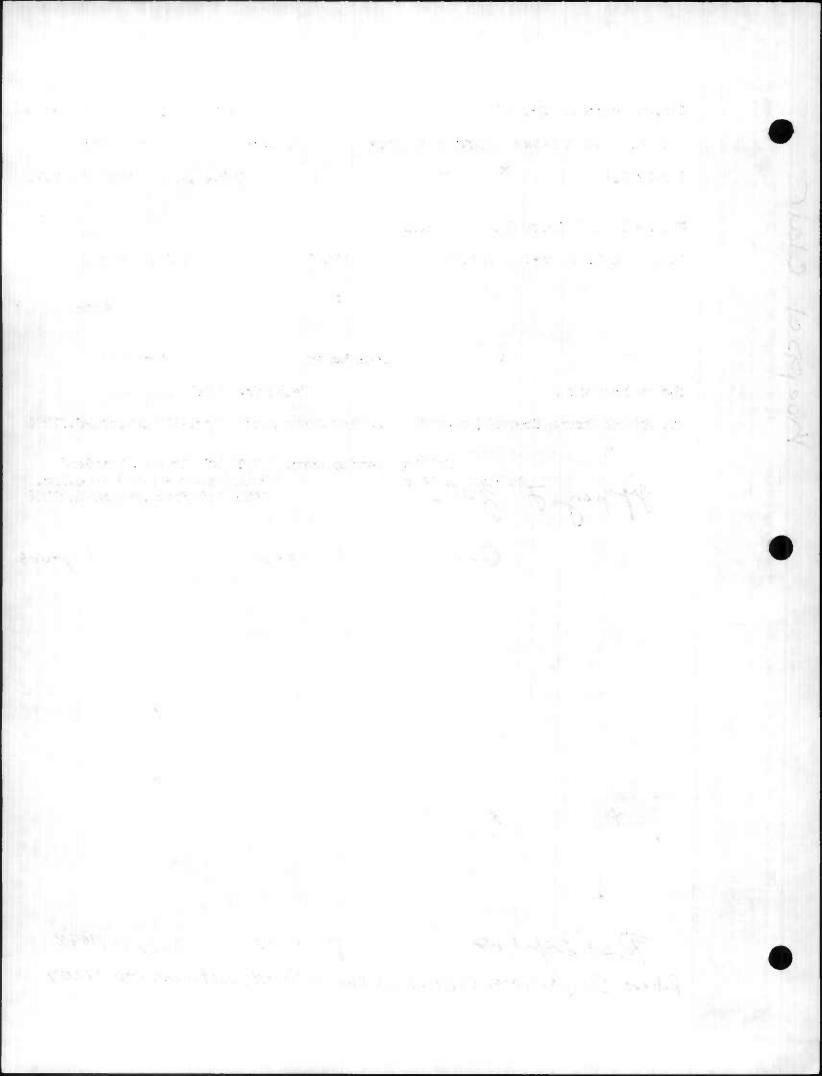
State of Maryland / Department of Health and Mental Hygiene

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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Tuly 13, 1998 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert Shepark Mp, 6569 North Charles Street, Paltmae, Mp 21204	eletely filler	(Check only 2 Medical Exam	fnar: On the basis of examina								
8 Robert Slepal, NO D52816 July 12, 1998 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) Robert Shepark mp, 6569 North Charles Street, Baltmae, mp 21204	M M	29b. Signature and title of certifier			29c. Lice	nse number		29	d. Date signe	ed (Month, De	ay, Year)
30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) Pobert Shepark mp, 6569 North Charles Street, Paltmare, mp 21207	/	1 Ket Ster	bal, No		D	528	10	-	Tuly	12/	998
Robert Shepark Mp, 6569 North Charles Street, Baltmare, MD 21204	$ \sqrt{} $	20 Name and address of names into	completed source of death //t	n 23a) (Time Di	int)			, ,	/		
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State 31. Dete filed (Month Dey, Rear) 1998 32. Registrar Signature Thands 62		31. Dete filed (Month Dev Rear) 100	32. Registrar Sigh	ature &		- 1	- /				

State Registrar

Division of Vital Records, P.O. Box 68760,

Moe Mayland 21215-0020



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Dev Yea **Physician** LONAKONIS SHIRLEY JULY 9, 1998 19:55 P /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 200F Months Deys Hours Yrs. Director 213-26-1037 71 Nov. 16,1926 Maryland Usuai Rasidence of Dacedant the Maryland 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 ☑ No Directo Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? filed within 72 hours after death with thygiene.
ther than "natural", or items 23a or 's ent, the Medical Examiner must be in 21222 United States 206 Pinewood Road Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2√☐ No If Yas, Give Yaar or Datas: 14. Race - Amarican Indian, 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) Black, Whita, atc. 1 ☐ Never Merried 25th Married 1 ☐ Yas 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 18a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) Coilega (1-4or 5+) 12 Years Clerical Social Security 7 is marked other traumatic event, i 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Fethar's Nama (First, Middle, Last) . Pages 1 end 2 should be file timent of Health and Mentel Hy tant: If Item 27 is marked oth jury or other traumatic event Be Philip Louis Rueckert Bertha Hochstedt 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Mr. John Lonakonis/Husband 206 Pinewood Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition permit. Pages Department of Important: If it any injury or o XX Burial 2 Cramation 3 Ramovat from Stata Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7/13/1998 Parkville, Maryland 22. Nama and Addrass of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Eugeni Service Licenses 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications that imused the death. Do not anter the mode of dying, such as cardiec or respiratory arrast, shock, or heart failure. List only one cause of each line. Approximeta Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final seven days myocardial infarction disaasa or conditio resulting in daath) Examiner Due to (or as a consequence of): Physician/Medical Examiner disease unknown coronary artery Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury The lew requires that the death certificate bears Division of Vital Records, P.O. Box 68760. that initiated avants resulting in death) Last Dua to (or as a consaquance of): attending p signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown hypoxic encephalopathy à 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? is certificate has director, page 2 1 Yas 2 No 1 Yas 2 No Physician: 26. Placa of Death (Check only one) Be 25. Was casa referred to medical exeminer? Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospital: 1 Yas 2 No 10 1 Inpatient 2 □ ER/Outpetient 3 □ DOA this funeral 28e. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: After or Attending Natural 5 Panding 1 ☐ Yas 2 ☐ No death. Invastigation Director: A 2 Accident 6 Could not be determined 3 ☐ Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Specify) in 24 hour. 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

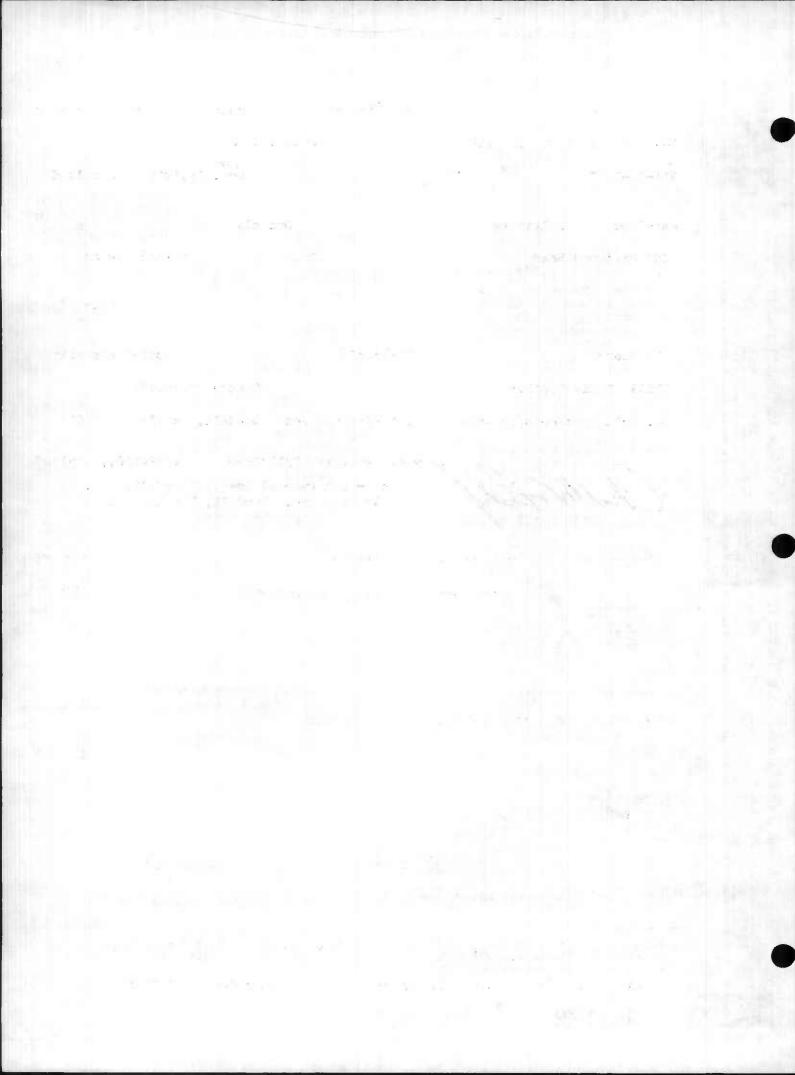
| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medicai (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titta of certifiar 29c. Licansa number RES-000 MD sand 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) JANET JHH DEPARTMENT OF EMERGENCY MEDICINE BAULD 31. Data filed (Month, Day, Year) 32 Registrar's Signatura

Julia Davidson Mandall.

DHMH 16 Rev 6/95

Registrar

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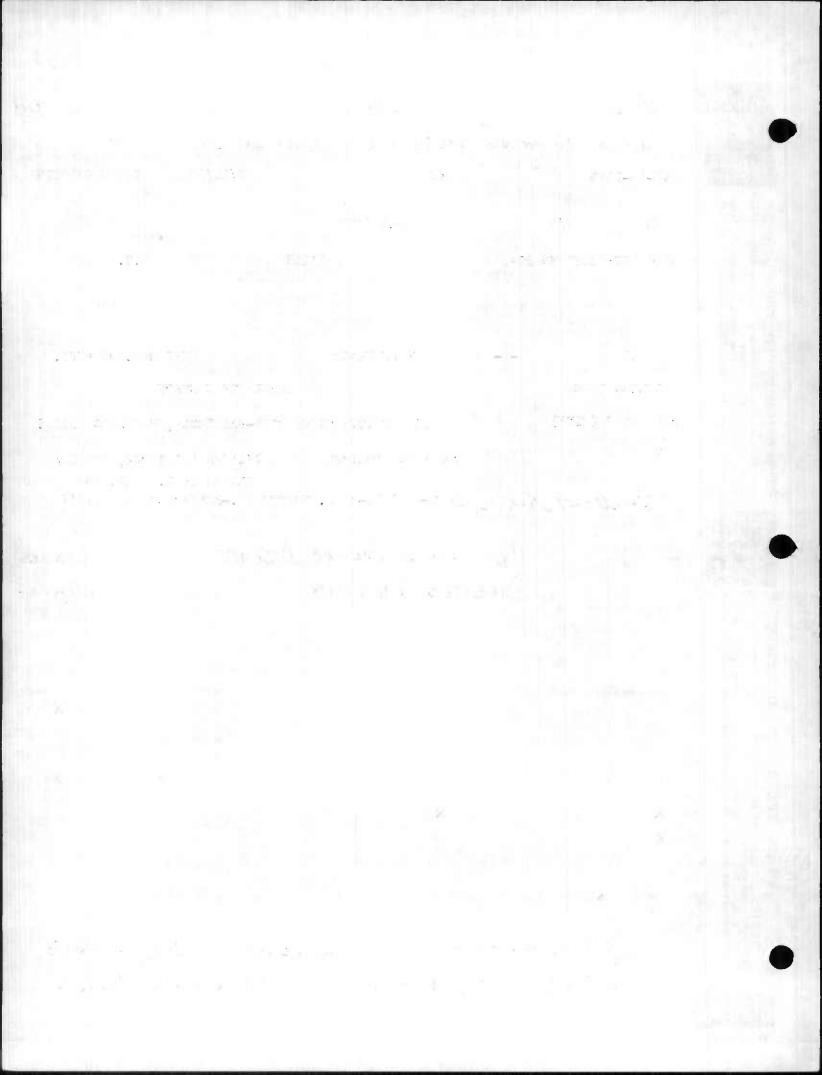


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** LONG 1998 10:54AM ILLIE ULY /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner BALTIMORE CITY |
If Under 24 Hrs. 8. Date of Birth
Min. (Month, Dey, Year) OPKINS HOSPITAL JOHNS N/A If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys 15€M 2□ F Yrs 63 **Director** 3/11/35 SOUTH CAROLINA 247-56-7460 Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 3444 REISTERSTOWN ROAD U S ... 14. Rece - American Indian, Black, White, etc. Funeral 21215 death 12. Was Decedent Ever In U.S. Armed Forces? XIX Yes 2 \(\subseteq \text{No}\) If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stafus permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or iter any injury or other traumatic event, the Medical Examinat 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 -0-MAINTENANCE CITY HOUSING DEPT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) GLENTON LONG CHARLOTTE JOHNSON 19a, Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) RYAN LONG (WIFE) 3444 REISTERSTOWN ROAD-BALTIMORE, MARYLAND 21215 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State WOODLAWN CEMETERY 7/11/98 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility ELIZABETH L. PHILLIPS 1721-27 N. MONROE ST.-BALTIMORE, MD 21217 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician HYPERTENSIVE CARDIAC DISEASE fmmediate Cause (Final disease or condition resulting In death) /Medical 20 YEARS Examiner BETES 2DYEARS 1ELLITIS Examin Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last pue Due to (or es e consequence of) physician Physician/Medical 94 Due to (or es a consequence of) = use Pert fl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contributa to the cause of death? 2 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 X Unknown B Vital Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? Completed has 1 Yes 2 No 1 ☐ Yes 2 No certificate 25. Wes cese referred to medical exeminer? Be 28. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2X ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 XYes 2 No 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and menner as stated. edical Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred of the time, dete end place, and due to the cause(s) end manner stated. (Check only To the P within 2 To the P 29b. Signature end fitte di certifier 29c. License number 29d. Date signed (Month, Dev. Year) rson who completed cause of deeth (Item 23e) (Type, Print) 30. Name and address of pr Wolfe St. Bultmore Kodenik 600 NI

State Registra

31. Date filed (Month, Dev. Year)

32. Reg



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death ORCIA 2010 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore City Joseph Richey Hospice Baltimore If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Deys 1 ☐ M 2 ☑ F 585-80-1871 Yrs 61 Feb. 11, 1937 England Usual Residence of Deceden 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Maryland Prince Georges Tample Hills 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2309 Olson Street 20748 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 St Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Pharmaceutical Assistant 0 Unknown 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Unknown Unknown 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Betty Dunlop/sister unknown 20e. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donetion 5 ₩ Other (Specify) in state 21. Signature of Funeral Service Licensee Van 22. Name and Address of Fecility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20 montes GLIOBLASTOMA MULTIFORME Immediate Cause (Final Due to (or as a consequence of): Due to (or as a consequence of). Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a, Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Items 23a

þ

Completed

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Experience.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

that the death certificate be

signed d be det

page 2 :

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After

e Hospital or Attending P 24 hours after death. • Funeral Director: After I

To the Hospital of within 24 hours at To the Funeral D completaly illed

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Completed

89

Certification: To

edical

death with ò

> Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 405 PICE

25. Was case referred to medical examiner? 1 Yes 2N No 27. Manger of Death 1 Notural

2 Accident 3 Suicide

4 Homicide

5 Pending investigation B ☐ Could not be

1 ☐ Inpatient 2 ☐ ER/Dutpatient 3 ☐ DOA

1 □ Yes 2 □ No

28d. Describe how injury occurred

ertifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Cartifier

29b. Signature and title of certifier 29c. License number

29d. Dete signed (Month, Dey, Year)

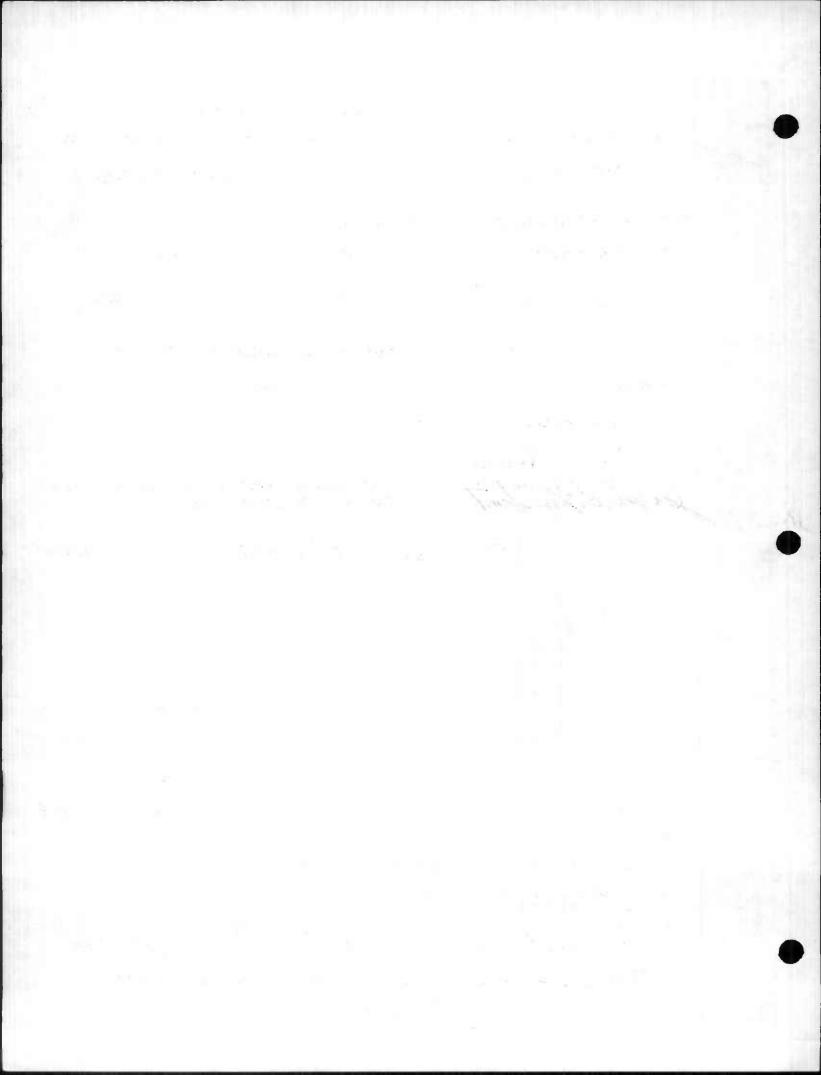
Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MD NOW, READ, ST. BACTIMORE HA 21201 MACGIBBON 31. Dete filed (Month-Da

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 98^{eer} Month Day 26 Douglas Winslow Murphy 1:12pm 4a. Facilify Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death

Takoma Park, MD

Prince George's

10d. inside City Limits

20011

29d. Date signed (Month, Day, Year)

20910

Takoma Park, MD

Approximate Interval Between Onset and Death

Yes 2 No

Physician /Medical **Examiner**

Washington Adventist Hospital

Funeral Director

with the Maryland 28a-f show treumatic event, the Medical Examiner must be notified at ò pemit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a
any injury or other treumatic event, the Medical Examiner mans 200.

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

P.O. Box 68760 The law requires that the death certificate ed by the a been signed be should be dete Records. page 2 should After this certificate has of Vital To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral Division

Physician/Medical Examiner þ Completed Be Certification: To Medical

6. Sex 1∕ M 2 F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Yrs 579-26-6110 8-6-27 Washington, DC Usual Residence of Decedent District 10b. County 10c. City, Town or Location of Columbia Washington 1901 Street and Number tal St. NW 10f. Zip Code 10g. Citizen of What Country? Washington, DC Funeral 20002 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 11. Marital Status 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PHZIVEZZ OWn Tailor 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be 2 Harvey Orlanda Murphy Annie Jane Putty Murphy

19b. Mailing Address (Street end Number of Hural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Kim Pridgen-Grand Daughter 4204 Arkansas Ave., NW Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) Ft. Lincoln Cemetery 7-1-98 Suitland, MD 21. Signature of unerai Service Licenses 2 amegy Adrep directal Home 3831 Georgia Ave. NW, Washington, DC 23a. Part1. Inter the disease, a complications that ceused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dylng, such as cardiac or respiratory errest, immediate Cause (Final diseasa or condition resulting in death) Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings avellable prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28c. injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

TimeCertifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, end due to the ceuse(s) and manner stated.

29c. License number

State Registrar 31. Date filed (Month, Day, Year) JUL 1 3 1998

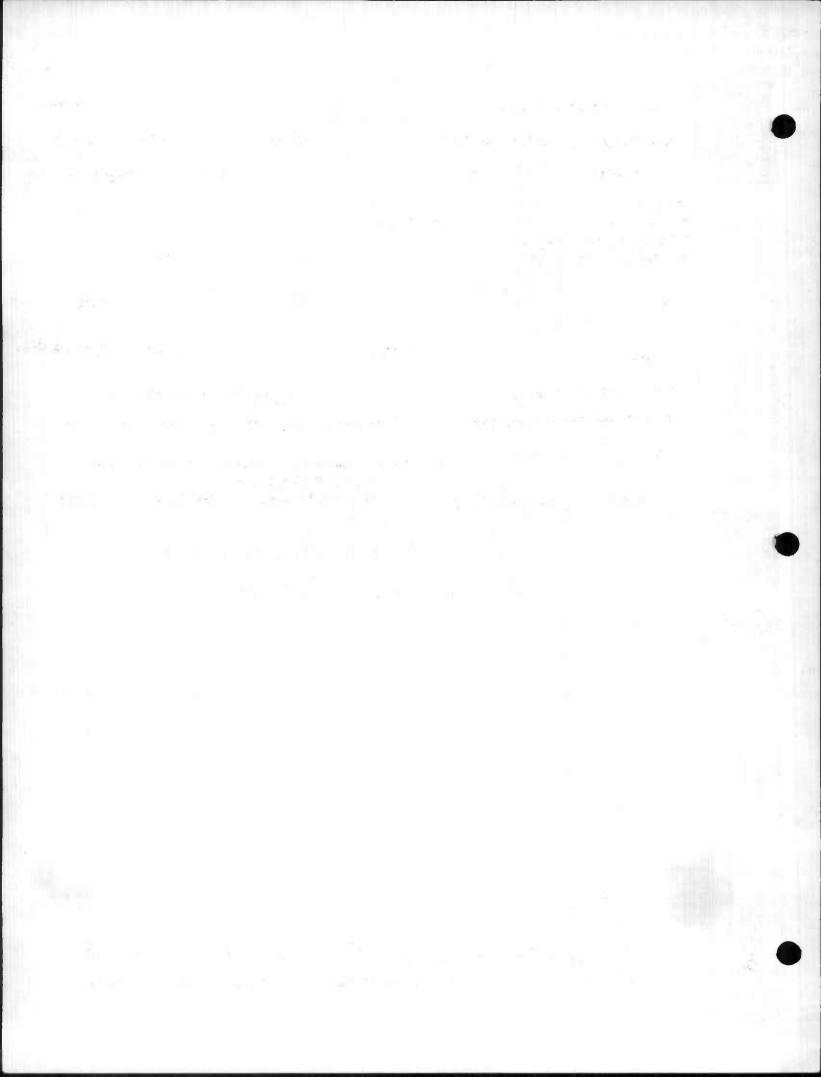
30. Name and address of person who comp

29b. Signature and title of certifier

29a. Certifier (Check only one)

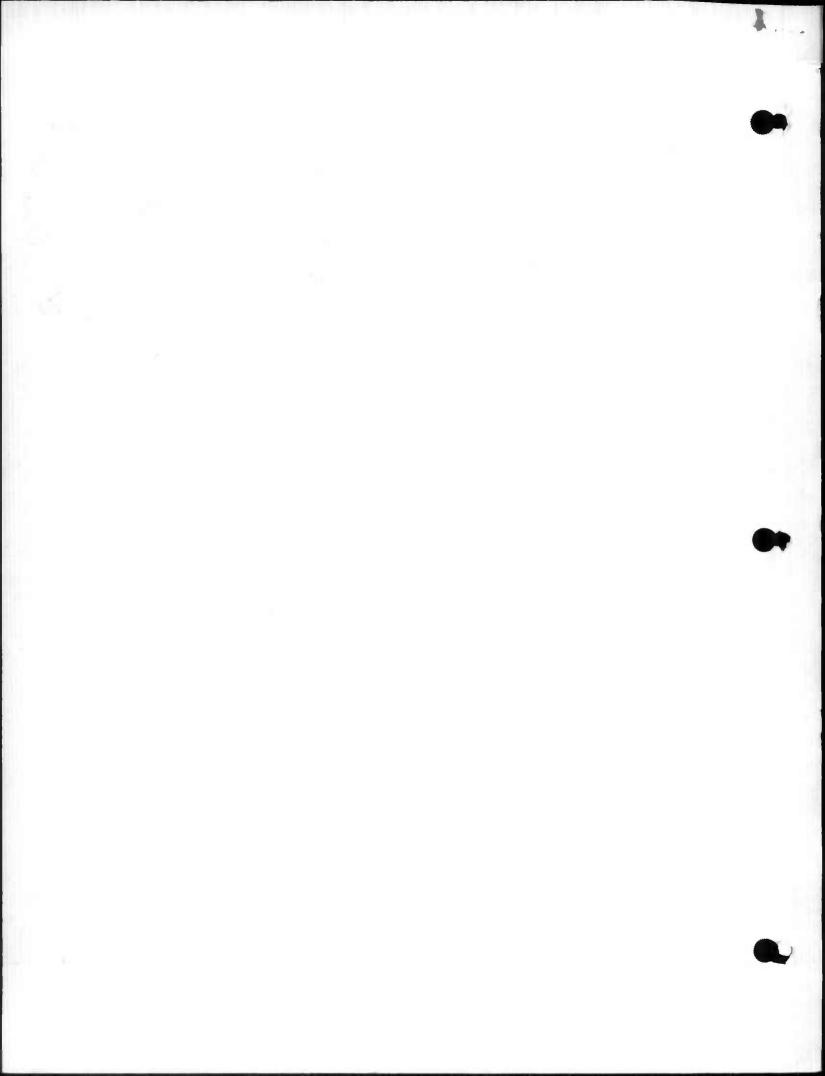


led danse of deeth (Item 23a) (Type, Print)

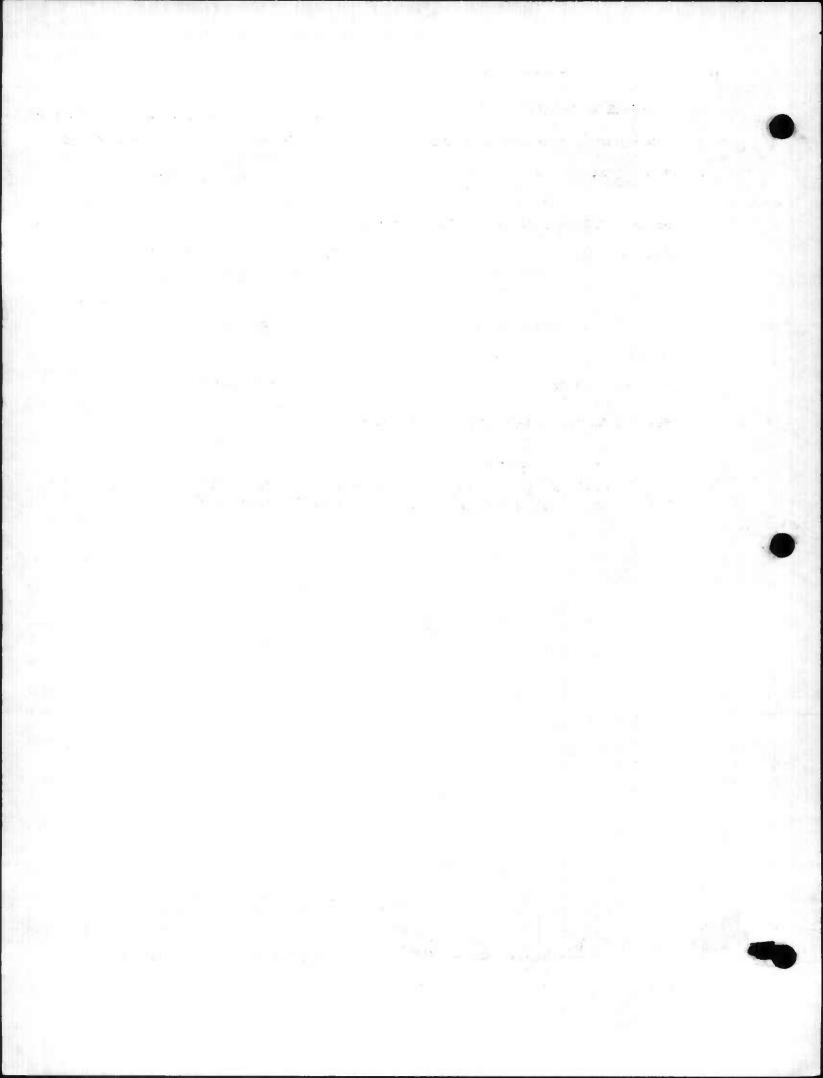


STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	ATE OF DEATH	1	REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)	,			2. DAT MON	E OF DEATH TH DAY	YEAR 3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. lest birthday)	FUNDER 1 YEAR IF UNDER 24	C	E OF BIRTN	98 3:05 711
	0.01: 01 01 111	1 M 2 X F				11h, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
	9e. FACILITY NAME (If not institution, give stre	et end number)		b. CITY, TOWN OR LOCATION	OF OEATH	110101	INTY OF DEATH
0 R	Glern Menoo	us Retire	HOKEL HOME	Gler ARN	4	B	Altimore
DIRECTOR	10e. STATE 10b. COUNTY	, •	10c, CITY, 1	TOWN OR LOCATION			10d. INSIDE CITY
	MARYLOND BOX	emore	Hle	NARM			1 Tes 2 No
FUNERAL	11630 Hlen,	Sem Rd.		101. ZIP CODE	157		USA
	1 Never Merried 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 X NO	13. WAS DECENDENT OF I	NISPANIC ORIG Mexican, Pueric Specify:	IN? (Specify Yee or No-	14. RACE — American Indian, Black, White, etc.
D BY	3 X Widowed 4 Divorced			7			INVITE
Ш	15. DECEDENT'S EDUCA (Specify only highest grade co	ompleted)	(Give kind of work iffe. Do NOT use n	k done during most of working	16	b. KIND OF BUSINESS/IN	DUSTRY
IPLI	Elementary/Secondary (0-12)	College (1-4 or 5+)	School	Hachop.		NUST VIR	ginia
COMPLET	17. FATHER'S NAME (First, Middle, Last)	1 - 0		18, MOTNES	R'S NAME (First,	Middle, Malden Sumeme)	
BE	PRANK MILL	lek			LR411	a	
5	190. INFORMANT'S NAME (Typo/Print)	MPH	196. MAILING AC	DORESS (Street end Number or	Rupal Route Nui	night City or Town, State, Z	10 Code) 1 1131
	200 METNOD OF DISPOSITION	20	b. PLACE AND DATE OF I	DISPOSITION (Name of	IVE.	TE 20c, LOCATION	- City or Town, State
	1 Buriel 2 Cremetion 3 Ramov 4 Donation 5 Other (Specify)	al from State	metery, crematory or other		rednis	1999 Timoni	um Magulana
	21. SIGNATURE OF FUNERAL SERVICE LICEN	YSEE	11	22. NAME AND ADDRESS	OF FACILITY	ENANS FI	INDRAD CHADOS
	areigh _	L Well	12	2325 VS	PV Ro	Timonii	IM NA 2193
	23. PART i. Entar the diseases, or co- shock, or heart failure. Li:	mplications that cause	d the death. Do not	entar the moda of dying	, auch sa ca	rdiac or respiratory a	
	IMMEDIATE CAUSE (Final	/	awcii iiiig.				Interval Batween Onset and Daath
	disease or condition resulting in death)	dem	nlia				years
7		DUE TO (OR AS	A CONSEQUENCE OF):				0
101	Sequantially ilat conditions, If any, leading to immediate	OUE TO (OR AS	A CONSEQUENCE OF):				
RTIFICATIO	cause. Enter UNDERLYING CAUSE (Disease or injury						
TIF	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF):				
E C	d.						
DICAL	PART II. Other algnificant conditions	contributing to death	but not resulting in	the undarlying cause giv	en in Part I.	24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDIC						1 TES 2	COMPLETION OF CAUSE OF DEATH?
Σ							1 TYES 2 NO
IAN:	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEA	TN (Check only)	2001	
PHYSICI		HOSPITAL:	petient 3 DOA	THER:			
PHY	27. MANNER OF DEATN	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME C	28c, INJURY AT		ESCRIBE HOW INJURY OF	CCUREO
ВУ	1 Natural 5 Pending 2 Accident Investigation			M 1 YES 2 N	40		
ED	3 Suicide 8 Could not be 4 Nomicide determined	28e, PLACE OF INJUR' building, etc. (Spe	Y — At home, term, etre ecily)	et, fectory, office		CATION (Street end Number y or Town, State)	er or Rural Route Number,
LET	29a. CERTIFIER . SCORREGISTANO PARAMETER			No. of the same of			
COMPLET				it the time, date end place, er in my opinion, death occured			ited. the cause(e) end menner se stated.
D U	296. SIGNATURE AND TITLE OF CERTIFIER	1 1		29c. LICENS			TE SIGNED (Month, Day, Year)
0 8	Il Ansh	mylle	no	025	205	> 5	11.10 1998
۲	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DI	ENTN (ITEM 27) (Type, Pr	Charles St.	Ba	1 to m.1	31206
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	VATURE		1/11	7.14	-1207
1 8	JUL 1 3 1998	Sulia Da	waron-Handel	E.			



Ite	m#:	25,29a,30 per Phy G7		of Marylar EW		artment <i>rtificate</i>			nd Menta		g. No.	21	33:	3
Physicia: /Medica		1. Decadant's Nama (First, Middle CLARENCE R. ME							Mo	ta of Deatl onth	Day 1998	Year	3. Tima o	of Death
Examine		4a. Facility Name (If not institution, Mariner of S			d		4	b. City, Town	n, or Location		4c. County Prin		orges	
Funeral Director		479-12-8244	6. Sex 1 → M 2 □ F	7. Age (In yrs. 76	last birthday) Yrs.	If Undar Months	1 Yaar Days	If Under 24 Hours	Min. (Mi	ta of Birth onth, Day, . 14	Year) 1922	9. Birthpl Count Iowa	ace (State try)	or Foreign
, Maryland 21215-0020 and 2 should be filed within 72 hours after death with the Maryland selfs and Mental Hygiene. 17 is marked other than "natural", or items 23s or 28s-f show or traumatic event, the Medical Examinar must be notified at	Director	Usual Rasidance of Dacedent 10a. Stata 10b. County Maryland Prince 10e. Street and Number	Georges		ty, Town or Lo		Code			14	Og. Citizen of V			City Limits s 2 ☑ No
23a or		5517 Juth Road				20	0746			1	U.S.A.			
020 burs after death with the Maryian sal, or items 23a or 28a-1 show Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed F	2 No		Was Daced II Yes, spec 1 ☐ Yas 2		Ispanic Origir in, Mexican, I Specify:	n? (Specify Ye Puerto Rican,	es or No- etc.)		e - America k, Whita, a Bla	atc.	
iore, Maryland 21215-0020 ges 1 and 2 should be filed within 72 hours aft t of Health and Mental Hygiene. If item 27 is marked other than "natural", or or other traumatic event, the Medical Exam	Completed	15. Decedant (Specify only highest Elamentary/Secondary (0-12) unknown	t grade completed,	(1-4or 5+)	(Giva	DO NOT us	k dona d	durina most o	of working		unknow		lustry	
Baltimore, Maryland 212' pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is merked other than any injury or other traumetic event, that Hygies.	To Be Co	17. Fathar's Nama (First, Middla, L Herbert Menefe	ast)						s Nama (First n Kaiud		faiden Sumam	ia)		
Mar and 2 sho alth and 27 is m		19a. Informant's Name/Ralationship (Type, Print) Beverly Christenson/sister 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town unknown 20a. Mathod of Disposition 20b. Place of Disposition (Nama of competent of other place) Data 20c. Location										Stata, Zip	Code)	
Baltimore, semit. Pages 1 an Department of Heal mportant: If Nem 2 ny injury or other MGS.		1 Burial 2 Cramation 4 Donation 5 StOthar (Sp	Date	a 2	20c. Location -	City or To	wn, State							
Balt permit. Departi Import any inj pace.		21. Signatura of Finaral Sarvice L Ronald	S. Warde	Direct	or 2				oard, land 2		. Balt	imore	Stre	et
Physician (Maddas)		23a. Palt1. Entar tha disaasa, or shock, or haart failura. List				,	a of dyln	g, such as ce	erdiac or rasp	lratory arra	st,		Approxima Intarval Be Onsat and	tween Death
/Medical Examiner		Immediata Causa (Final diseasa or condition rasulting In death)		Small Dua to (auanaa allu		C to L.	1				Now	arks.
60, be executed clain and burial-transit	Examiner	Sequentially list conditions, if any, leading to Immediate ceusa. Entar Undarlying Cause (Disaase or Injury	b	n obato	or as a conse	quance ol):	1	· quan	m)				61	4416
8760 nate be physicia the bur	edical	ceusa. Entar Undarrying Cause (Disaase or Injury that initiated evants resulting In death) Last	ľ		or as a consec	quence of):		ino			_		1/0	a.
00 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Physician/M	Part II. Other significant condition	na contributing to d					an in Part I.	2		bacco uae co			of death?
Vital Records, P.O. ician: The law requires that the decentificate has been signed by the rector, page 2 should be detached	Completed by	Gulethias Sepsi	2						24	4a. Was ar perform	n autopsy ned?	24b. Wa	ara autopsy allable prior apletion of death?	findings to cause
tal Rec	Com	25 Was asso referred to madical								1 ☐ Ye		10	Yas 20] No
of Vita	10 86	25. Was casa rafarred to medicel examiner? 1 XYas 2 No	Hospital:	Inpatiant 2] ER/Outpatle	nt 3 DO	A Oth		of Death <i>(Che</i> sing Home 5		nce 6 □Oth	er (Specify	1)	
Division or Attending ther death. Inestor: After in by the fune	Certification:	27. Mannar of Death 1 🗹 Natural 5 Pending 2 Accident invastig 3 Suicide 6 Could n 4 Homloida	ation	of Injury nth, Day Year) a of Injury - At h ling, atc. (Speci	28b. Tima o Injury oma, larm, st	М		yat k? Yas 2∐No	o 28f. Lo		w Injury occurrent and Numb		l Routa Nur	n <i>ber,</i>
25.23	edical Ce	29a. Cartifiar 1 Certifying (Check only one)	Physician: To the examiner: On that	a best of my kno basis of axamina nnar stated.	owiedga, daat ation and/or in	h occurred a	at tha tin in my o	na, data and pinion, daath	place, and du occurred at ti	a to tha ca ha tima, da	usa(s) and ma ata and place,	annar as st and dua to	ated. tha causa	(s)
CAL.	me	29b. Signatura and titla of certifier	ange	2_	ms.	290	Licens	e number	0		9d. Data aigne		Day, Year)	
		30. Nama and addrass of person w Khosrow Davachi MD	-	,		,	shing	jton DC						
State	e	31. Data liled (Month, Day, Year)		Registrates Sign	Marketon.	Pando	0.							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death **Physician** Month SOPHIA MURPHY 4b. City, Town, or Location of Death CARTER 1616 hrs 98 /Medical 4e. Facility Name (If not institution, give street and number) 4c. County of Death Examiner MEMORIAL BALTIMORE CITY
If Under 24 Hrs. 8 Date of Birth MOINN HOSPITAL n/a 5. Social Security Number if Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) **Funeral** Days 1 □ M 2 💢 F Months Hours Yrs Director June 29, 1998 Maryland Usuai Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show itam 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exactings must be notified at NIA 12 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 2201 Sulgrave Avenue 21209 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural", or feel any injury or other traumatic event 1 X Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) n/a n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Joshua Carter Murphy Karen Blackmon 19e. Informent's Neme/Relationship (Type, Print) qrandmotherb. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2201 Sulgrave Ave. 21209 Betty Jean Murphy Baltimore, MD 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Special Arbutus Memorial Park July 9 Baltimore County, MD 21. Signatury of Funerel Samce Ligansee 22. Name end Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore, MD 21216 23a. Pen1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final PULMONARY disease or condition resulting in death) EMORRHAGE Examiner Due to (or es e consequence of) Examiner SEPTICENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be exe PREMATURITY Records, P.O. Box 68760. physician Physician/Medical he attending p MINT GFSTATION signed by the a d be detached t Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MEMBRANE þ 24b. Were autopsy findings evaileble prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? DUCTUS ARTERIOSUS 1 ☐ Yes 2 No 1 Yes certificate 2 No LNDOMETHADIN TREATMENT Division of Vital To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 Netural 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 31052

201E, WNIVERSITY

32. Registrer's Signature

guha Deurdon-Handere

PARKWAY

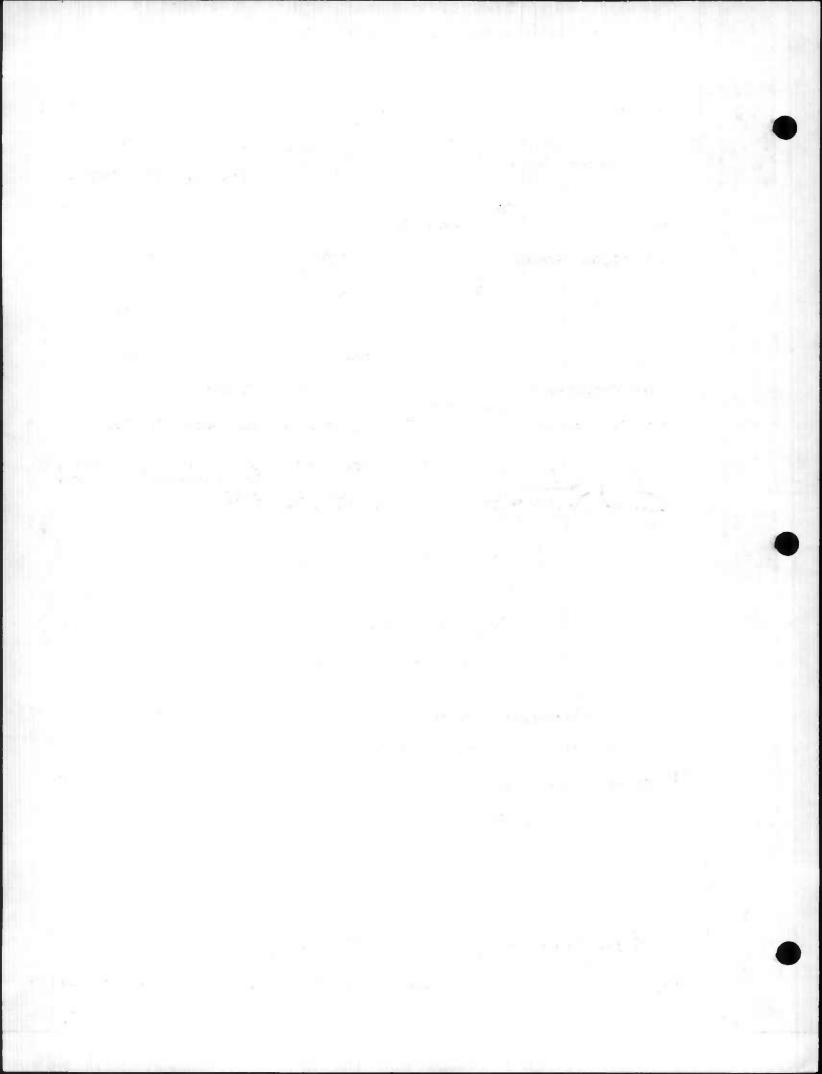
BALTIMORE ND 21218

State Registrar

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

GOPAL MD

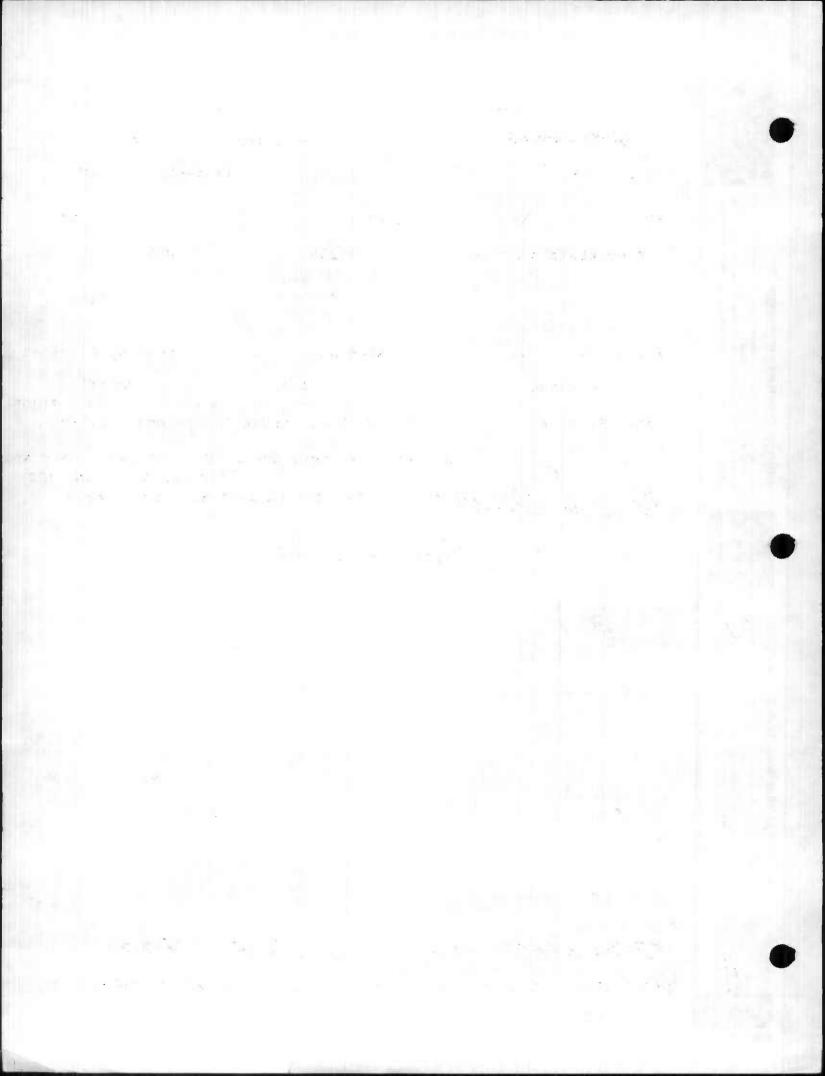
31. Date filed (Month, Day, Year)



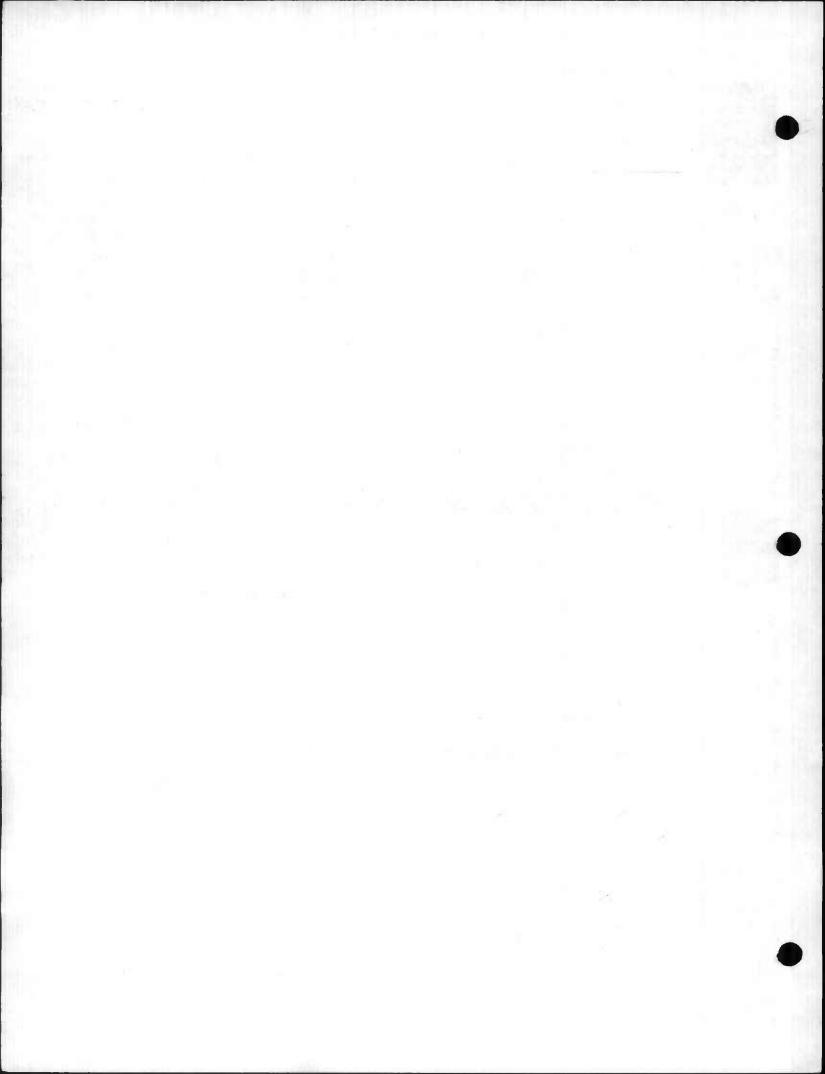
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

hysician		. Decedent's Name (First, Middle, L	ast)		00/11/1	cate of l	- Outi i	2. Dele of Deat			ime of Death
/Medical	ı	Shirley J. Morn	ris					June 30		Yeer 5:	20 PM
Examiner	4	a. Fecility Neme (If not institution, gi	ve street and number)		4	b. City, Town, or L		4c. County of		
	L	Prince Georges	Hospital				Cheverly		Hyat	tsville	
neral ector		381-30-4966	Sex 7. A 1 □ M 2 ☑ F	ge (In yrs. las 66		Inder 1 Year nths Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 27	, 1931	9. Birthplaca (S Country) Michig	State or Foreig
ž ==	-	Sual Residence of Decedent 10b. County		10c. City,	Town or Location	n				10d. Ins	side City Limits
notified at		Maryland Anne A	rundel		rchton						Yes 2⊠N
be notified Director	1	0e. Street and Number			10	of. Zip Code		1	0g. Citizen of W	hat Country?	
		5604 West Carv	el Drive			20733			U.S.A.		
miner must	1	Marital Status 1	12. Was Deceden Armed Forces 1 Yes 2	?			ispenic Origin? (Sp in, Mexican, Puerto		14. Raca Black	- American Ind	lian,
Eran d by		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 1 1	es 2⊠ No	Specify:		Specify:	Black	
rt, the Medical J	-	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade com <i>pleted)</i> College (1-4or			of work done o OT use retired	etion during most of work i)	ing	16b. Kind of Bus	siness/Industry	
를 S	-	7 Eatharia Nama (Sirat Middle Las	5+		Negot	iator	18. Mother's Nam	n (Finnt Mintella A	Union	-1	
Be o		7. Father's Na <i>me (First, Middle, La</i> s Cee Wood Huds	on				Ruth Tu		walden Sumame	9)	
To E	1	9a. Informant's Name/Ralationship	(Type Print)		10h Mailing Ad	drace (Streat	and Number or Rui		City or Town	State Zin Code	1
1 2	П	Jeffrey Morris			unknow		and rannon or riar	ar rioure reunioer	, Only of Towns, s	State, Zip Code,	,
ary or other tr	2	0a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 ☑ Other (Speci	Removal from State	cen	ce of Disposition netery, cremator	(Name of	(8)	Date	20c. Location - (City or Town, St	tete
any inja once.	2	1. Signature of Funeral Service Lice JOSE Ph		57			omy Boar Marylan		. Balti	more St	reet
	1	3a. Part. Enter the disease, or con	nplications that cause	d the death.					est,	Appro	oximete
cian lical liner	1.0	shock, or heart failure. List only mmediate Cause (Final issasse or condition esulting in death)	^	bral	VHC		Accid	ent			al Between it and Death
Examiner	100	equentisity list conditions, any, leading to immediate aute. Enter Underlying	b		s a consequenc	,					
	13	ause (Disease or Injury	C								
use as the bu	1	nat initiated events esuiting in death) Last	d	Due to (or e	s a consequence	a of):					
d for use	-	ari II. Othar significant conditions	contribution to death	huit mat manulti	na la tha cadad	dee eeura ek	se la Dard I	22h Dida	h-200 una com	tellareta ta tha a	nunn of dooth
d be detached for use		art II. Other significant conditions	contributing to death	oui not resulti	ng in the underl	ying cause giv	en in Part I.		es 2 No	3 Probably	4 Unknov
shouls letec	-				1			24a. Was a perion		24b. Were au eveileble completi of daath	prior to on of cause
N D								1 T V	2 XINO	1 🗆 Yes	20 No
8 E	1						26. Place of Deal	th (Check only on	10	1 100	2010
or, page	2	5. Was case referred to medical		ient 2∏EF	R/Outpatient 3	DOA Oth	an	oma 5 🗆 Rasida		r (Specify)	
nector	2	5. Was case referred to medical examiner?	Hospital:			28c. Injun Wor		28d. Dascribe ho			
To Be		examiner? Yes 20 No 7. Nanger of Death Natural 5 Pending investigation investigation	28a. Date of Inj (Month, D	ury ay Year)	8b. Time of injury M		Yas 2□No				
in by the tuneral director ertification: To Be		examiner? 1 Yes 2 No 7. Manner of Death Natural 5 Pending	1 A Inpat 28a. Date of In (Month, D	ay Year)	injury	10		28f. Location (St City or Town	treet and Numbe n, Stata)	er or Rurai Rout	e Number,
or by the tuneral director ertification: To Be	2	examiner? 1 Yes 2 No 7. Namer of Death Natural 5 Pending investigation of Death Suicide 6 Could not a determined of Death Homicide Could not a determined of Death	1 A Inpat 28a. Date of In (Month, D	ay Year) ijury - At hom ic. (Specify) of my knowled examination	injury N a, farm, streat, f	actory, office	Yas 2 No	City or Town	n, Stata) ause(s) and mar	nner as stated.	
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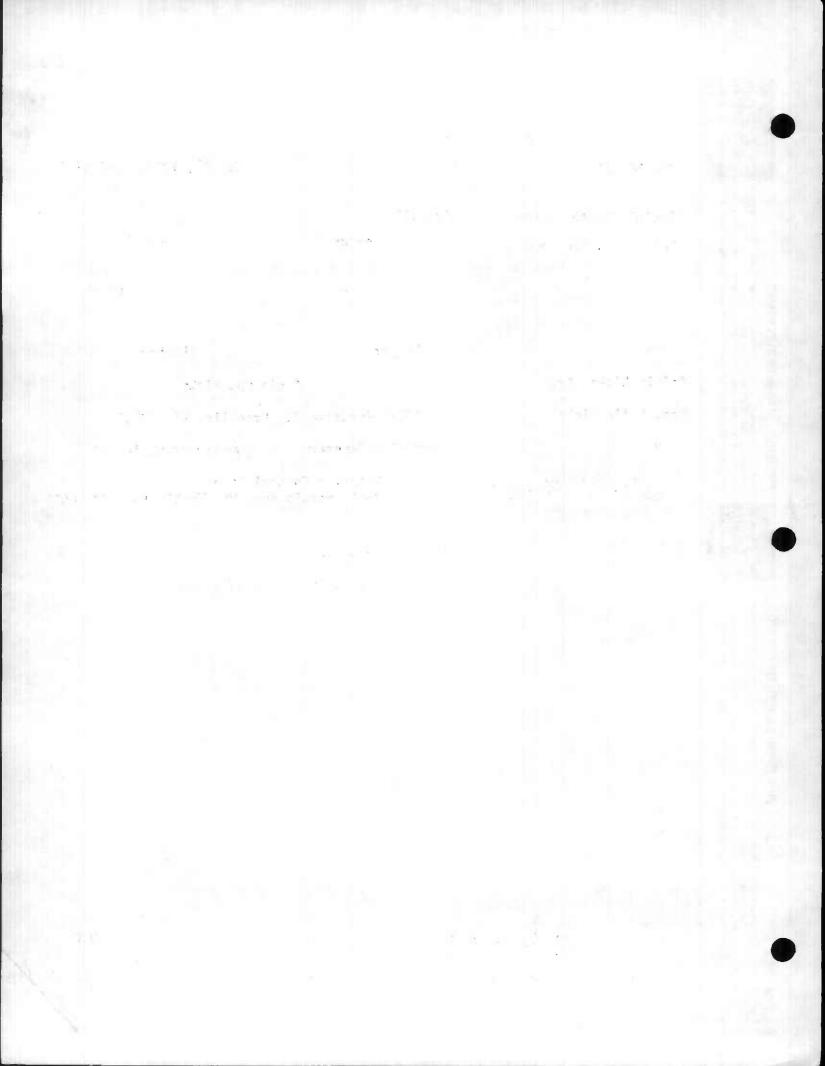
				State of M	aiyiaii		tificate of	Death		leg. No.	4	336	
	Dhualai		1. Decedent's Name (First, Middle, L	ast)					2. Date of Dea Month	th Dev	Year	3. Time of Dea	
П	Physici /Medio	_	Leon	Powell					July	08,	98	11:53	am
	Examir		4a Facility Name (If not institution, g)			4b. City, Town, or L		4c. County	of Death		
			704 N Eden S					Baltimo		NA			
	Funeral Director		218-60-5629	WEST A COL	ge (In yrs. 46	last birthday) _ Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day 12-14	7 Year) 1-51	9. Birthp Coun	lace (State or Fol try) NC	reign
	pue *-		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	ation				1	0d. Inside City Li	imits
	Aaryl Peho	5	MD	NA		Baltin						1 Xes 2 □	
	the 1	Director	10e. Street and Number				10f. Zip Code			l0g. Citizen of \	What Coun	try?	
	ter death with the Marylan flems 23s or 28s-f show her must be notified at		704 North Ed	en Stree	t		2120	5		USA		100	
	Jeath 2	Funeral	11. Maritel Status	12. Was Decedent	Ever In U.	S. 13. W		Hispanic Origin? (Spean, Mexican, Puerto	pecify Yes or No-		e - Americ		
Maryland 21215-0020	n 72 hours after death with the Maryland "naturel", or items 23a or 28a-f ehow edical Exactive must be notified at	by Fur	1 X Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Yeer or Detes:			Yes, specify Cub		Rican, etc.)	Specifi	ck, White,	ack	
Ö	2 hou	Completed	15. Decedent's I	ducation		16a. Decade	ent's Usual Occu	pation		16b. Kind of B	usiness/Ind	dustry	
215	C .	ple	(Specify only highest g Elementary/Secondary (0-12)	ade completed) College (1-4or	5+)	(Give k life. D	ind of work done O NOT use retire	pation during most of work ad)	king				
2	DO	mo.	11th Grade	NA	V+)	Cus	stodian	1		Broad	way	Service	es
D	m - 0 =	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Nam	e (First, Middle,				
Na	should be and Mental marked o	To	Unkno	wn				Inez			Powe	11	
ar	end end end		19a. Intormant's Name/Relationship					t and Number or Ru					205
	54 T		Inez Simmon	S				n Stree					
ore			20a. Method of Disposition 1 Durial 2 □ Cremation 3	Removal from State		ametery, crem	ition (Name of atory or other pla		Date	20c. Location			
E	Peges ment of I ant: If its ury or o		4 □ Donation 5 □ Other (Spec		Mt	. Zior	n Cemet	ery 07+				, Mary	
Baltimore,	pemit. Peges Department of Importent: If it any injury or once.		21. Signature of Funeral Service Uco	Inter	411		M.C.Mai	ess of Fecility E			_	nd 212	02
			23a. Panti. Enter the disease, or con shock, or heart tailure. List onl	nplications that cause	d the deeth	n. Do not ente	r the mode of dy	ing, such es cardiac	or respiretory er	rest,		Approximete Interval Between	
A	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a	Due to (o	RD/OA r es a consequ r as a consequ	ienca ot):	7-744					
Ô			Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying								-		
68760,	ng physicie es the bur	Medical	Ceuse (Disease or injury that initiated events resulting in death) Last	C	Due to (or	r as a consequ	enca ot):						
Box	deeth certific e ettending p ed for use es	Physician/M		d									
	0 0 2	Sici	Part II. Other significant conditions	contributing to death I	out not resi	uiting in the un	derlying cause g	iven in Part I.	23b. Did t	obacco use co	ntribute to	the cause of de	eath?
s, P.O	gned by be detac	by Phy							101	res 200 No	3 Pro	bebly 4 Unk	cnown
of Vital Records,	2 s	Completed								en eutopsy rmed?	ev	ere autopsy tindii ailable prior to mpletion ot causi death?	
ř	The law ate has b page 2 s	EO							101	es 2 No	1[Yes 2 No	
ta		Be	25. Was case reterred to medical					26. Place of Dee	th (Check only o	ne)			-
>	0 0	To	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	ient 2 🗆	ER/Outpetient	3□ DOA O	her: 4 Nursing H	ome 5 Resid	lenca 6 □Ott	ner (Specif	у)	
	ding h. After funa		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	28e. Date of Inj (Month, Di	ury a <i>y Year)</i>	28b. Time of injury	28c. Inju Wo M 1	iry et ork?] Yes 2 □ No	28d. Describe h	now injury occur	rred		
Division		Certification:	3 Suicide 6 Could not determine	28e. Placa of in	jury - At ho tc. (Specify	ome, tarm, stre	et, tactory, office		28t. Location (S City or Tox		ber or Rure	al Route Number,	,
		edical		hysician: To the best miner: On the basis of and menner s	t examinat								
	within To the To the comple	X	29b. Signature and title of cartifier					se number		29d. Date signe			
	1		March	ff.	Mis	?	D	3730	4	7.9.	75		
	,]		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type, F	Print)		-				
	7		MARCSHIFFHAN	1 MUSELOC	45AL	HES.W.	15x 78	3730 19 Bosza	NST B	ALTK	10 2	1224	
	Sta Registr		31. Date filed (Month, Dey, Year)	32 Regist	rar's Signa	ture Brida	V.						



I tem#	5 p	er FH G762 8/4/98		r Maryland	Cer	rtment of F	nealth a Death	ind Menta	Hygie Reg.		21	337
Physic /Med		Decedent's Nema (First, Min LUCIE PALACII						2. Date Mon		Dey	Voor	3. Time of Deeth 2:25A
Exami	ner	4e. Facility Neme (If not institu JOHNS HOPKINS			ENTER		•	wn, or Location of	Death	4c. County		
Funeral Director		5. Social Security Number 820 03 6725 217-18-6755 Usuei Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under	Min. (Mor	of Birth oth, Day, Ye 18, 1	910	9. Birthplec Country, FRAN	a (Steta or Foreign) ICE
show		10e. State 10b. Cour	nty	10c. City,	Town or Loc	cation					10d.	Inside City Limits
the Man 28a-f st notfiled	ctor	MD	CITY	BA	LTIMO	RE CITY						1 X Yes 2□No
death with the Maryland ms 23a or 28a-f show Linual be notified at	al Dire	10e. Street and Number 436 JOPLIN ST	REET			10f. Zip Code 21 2	224		10g.	Citizen of V	Whet Country U.S.	
_ p 2 2	by Funeral Director	11. Maritai Stetus 1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divord	Armed For larried 1 ☐ Yes If Yes, Giv	2 X) No a	lf lf	/as Decedent of H Yas, specify Cub	Ilspanic Origan, Mexican Specify:	gin? (Specify Yes , Puerto Rican, e	or No-	Bled	a - Amarican ck, White, etc	
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≥ DEF		19e. Informent's Neme/Relation WILLIAM C. SC				g Address (Street MLA STRE		r or Rural Route BALTIMA(
Baltimore, Incoming the popular of Health Important: If then 27 my injury or other the page.		20a. Method of Disposition 1 Burlal 2 Cremetlo 4 Donation 5 Other	n 3 Removel from S	carr	etery, crem	ition (Nema of etory or other pla EMETERY	ce)	Dete 7//-			City or Town	, Stete ARYLAND
Physician /Medical Examiner	Examiner	23a. Pent? Enter the disease, shock, or heart failure. Unmedlete Ceuse (Finel disease or condition resulting in death) Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying	or complications that coist only one cause on each	Due to (or e	Do not anta	vance of):	ng, such es	cardiec or respire	otory errest,	, one,	A	AND 21224 pproximate tervel Between neet end Deeth
death certificate research of for use es the bun	Physician/Medical I	cause. Enter Underlying Ceuse (Diseese or injury that Initiated avents resulting in deeth) Last	d	Dua to (or e	s e consequ	ence of):						
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of Vita Physician: this certific	10	examiner?	Hospital:	patient 2 EF	VOutpatient		4 LI NU	rsing Home 5	Residenc	a 6 Oth	er (Specify)	
ion (ation:	E E Mooidorit	stigetion	h, Dey Year)	3b. Time of Injury	M 1□	yet k? Yas 2⊡t		cribe how	injury occuri	red	
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Hospit 24 houn Funeral letely fills	edical (29a. Certifier (Check only one) Certifier Check only one)	ying Phyelcian: To the la al Examiner: On the ba and menn	sis of exeminetion	edga, daath n end/or invi	occurred at the tir astigation, in my o	me, dete en plnion, deet	d piece, end due th occurred et the	to the ceus time, dete	e(s) end me end pleca,	enner es stete end due to th	ed. e ceuse(s)
To the To the	Me	29b. Signature and title of carti				29c. Licans	e number	9	29d.		d (Month, De	200 - 2110
6		30. Name end eddrass of person	on who completed cause	a of death (Itam 2		Print)	15 0	1153	300	310	177	M
St	ate	31. Deta filed (Month, Day, Yea		ogiality Signatu	3 %	and DO	=					-



sician	1. 0	Decedent's Name (First, Middle, La			30,11	ficate of		2. Date of Do		Velile	3. Time of Death
dical	L	CALVIN K		ICS				JUNE	30	Year 1998	7:24 PM
miner	4a	Facility Name (If not Institution, gives BALTIMORE		SPI	TA (r Location of Deer		of Deeth	
al or		Sociel Security Number 6. S	Sex 7. Age		est birthdey)	f Under 1 Year Months Days			rth ay. Year) 1933	9. Birthpi Count V I	ace (State or Foreign try) rginia
	-	uat Residence of Decedent a. Stete 10b. County		10c, City,	, Town or Locat	tion				10	Od. inside City Limits
tor	V	irginia South Ha	moton	Fra	anklin						1 □ Yes 2 No
al Director		a. Street and Number 8320 Burdette Ro				10f. Zip Code 23851			10g. Citizen of 1 USA	What Coun	try?
by Funeral	•	Maritei Status 1 ☐ Never Married 2 → Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 2 Yes 2 N If Yes, Give Year or Dates:	Ever in U,S	5. 13. Wa	s Decedent of I es, specify Cub Yes 2 No		(Specify Yes or Norto Rican, etc.)	Bla	ce - America ck, White, e by: Blac	etc.
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	17.	6th Father's Name (First, Middle, Last,)		Logger		18. Mother's N	ame (First, Middle	Lumber a, Meiden Sumen	ne)	
To Be		lvin Ricks, Sr.						Mae Ric			
-	19	a. Informant's Name/Relationship (Type, Print)				and Number or i	Rurel Route Numb	per, City or Town	, Stete, Zip	Code)
	-	s. Lelia Ricks		anh Di	18320 ece of Dispositi	Burdet	te Rd, F	ranklin,	VA 238	-	Photo
once.	208	a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		\$0	uthview	r Cemete			Frankli		
OUCE		Signeture of Funeral Service Licer a. Part1. Enter the disease, or com	mid Sauce	cers			Funera		ach i na ta	n DC	20011
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kamlr	Se	quentially list conditions,	b. C	ERE	BROV as a conseque	ASCUL	IR A	CCIDEA	JT	1	
an/Medical Examiner	res	quentially list conditions, only, leading to immediate use. Enter Underlying use (Disease or injury it initiated events sulting in death) Last	b	BRE Due to (or	BROV	ASCUU nce of):	IR A	CIDE A	JT		
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by Physician/Medical	Par	during in death) Last	b	BRE Due to (or	BRO V as a conseque	ASCULA		23b. Dld	I tobacco use co	3 Prob	V
by Physician/Medical	Par	during in death) Last	b	BRE Due to (or	BRO V as a conseque	ASCULA		23b. Did 1	I tobacco use cc] Yes 2□ No s en eutopsy	3 Prob	pably 4 Unknown are autopsy findings aliable prior to mpletion of cause
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:01 Am EVELYN & Ridgely 46 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Beath 1998 09 /Medical 4c. County of Death Examiner Baltimore Mary land Sex 7. Age (In yrs. last birthday) 5. Social Security Number of Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, May 15 9. Birthplace (State or Foreign If Under 1 Yeer 1□ M 2M F Months Deys 84 Yrs. Maryland 215-09-7783 Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Director Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 8935 D Waltham Woods Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify λq 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Heckner Bortle Joseph Hester R. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) Mrs. Carol Howard /Daughter 2201 Hamilton Ave. Baltimore, MD. 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 7-13-98 Towson, MD. Hilltop Service Co. 21. Signature of Funeral Service Licensi 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Examiner Ti Organ S Due to (or as a consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lesf Trauma Physician/Medical CERTIFICATION APPROVED BY MEDICAL EXAMINER 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 20 No 3 Probably 4 Unknown ease ρ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 12 Yes 2 No Be 28. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Pedestrian Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 1 ☐ Yes StruckByant investigation 22 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e 4 ☐ Homicide Unknown

sicien and burial-transit The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760 use a signed by the a been si s certificate has t or Attending Physicien: funeral director this After n 24 hours after death.

Ne Funeral Director: All pietely filled in by the fu death. Hospital To the Fune within 2

Funeral

Director

"naturel", or items 23s or 28s-f show

with the Maryland

permit. Pages 1 end 2 should be filed within 72 hours after death with Department of Heelth and Mental hygiene. Important: If item 27 is marked other than 6 any injury or other treument.

Physician /Medical

Examiner

29a. Certitier

(Check only one)

ober

State Registrar 29b. Signature agd 4tte of c

29c. License number

Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner es stated.

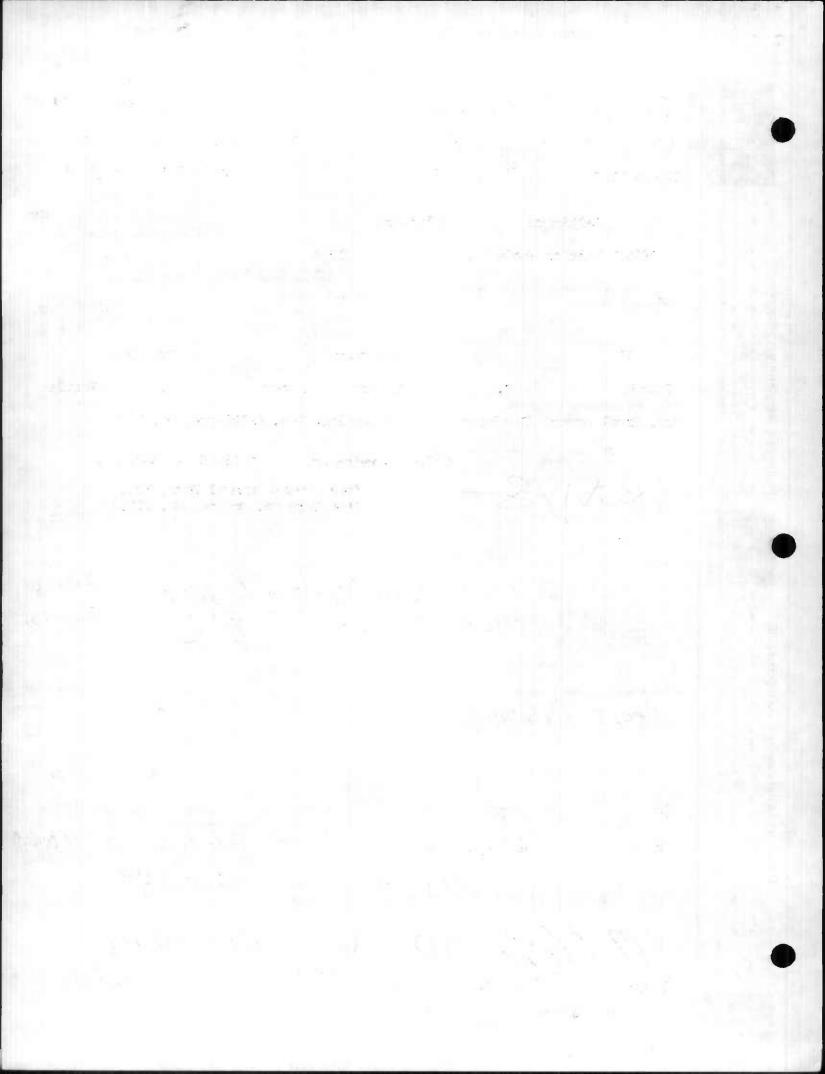
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

cause of deeth (Item 23e) (Type, Print)

Maryland, 22 5 Greene ST Baltimore Univ

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 1 3 1998 Tulia Davidson Randall

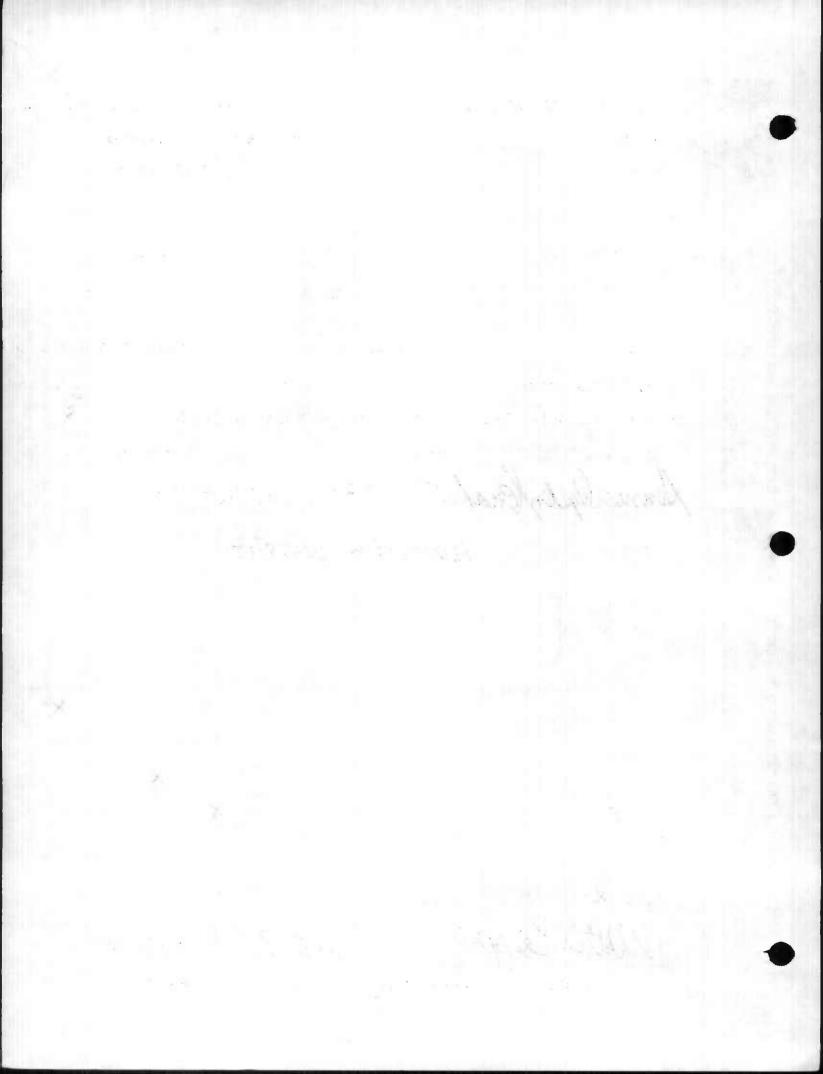
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				State of Maryl		rtment of F tificate of			giene Reg. No.	3 2	1340
	Dhuaisi		1. Decedent's Name (First, Middle, Last))				2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medi		Bertha Mae Sto	res				June			2:00pm
	Examir		4a. Facility Neme (If not institution, give s				4b. City, Town, or Lo	cation of Deeth	4c. County	of Deeth	200
L			Randolph Hill N	9			Wheaton, M		9	omery	
ı	Funeral Director		203-30-4654	х Эм жоғ 84	vrs. last birthday) Yrs.	If Under 1 Yeer Months Days	Hours Min.	8. Date of Bir (Month, Da June	10. Year) 26, 1913	9. Birthpie Counti Wash i	ngton, DC
	B & 11		Usuai Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	cation				10	d. Inside City Limits
	Mary Fash	ğ	PA Allegher	nv	Pittsbu	ırah					1 XYes 2 □ No
	r 28a	Director	10a. Street and Number	.,		10f. Zip Code			10g. Citizen of V	Whet Country	y?
	ser death with the Maryar Itsms 23a or 28a-f show iner must be notified at		550 Negley Run B	Blvd.		15	206		USA		
	dear dear	Funeral		12. Wes Decedent Ever in Armed Forces?	n U,S. 13. V		dispenic Origin? (Spean, Mexican, Puerto	ecify Yes or No	- 14. Rac	e - America	
Maryland 21215-0020	E 9 E	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		☐ Yes 2 No	Specify:	nican, etc.)	Specify	ck, White, e	ack
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and	8 E B B	Be	17. Father's Name (First, Middle, Last) Solomon Edward	Washington			18. Mother's Neme			10)	
2	should nd Mar marks ametic	٩	19a. Informant's Name/Relationship (Ty)		10h Mailin	a Address (Ctrast	and Number or Rura			Otata Tin I	2-4-1
Ma	and 2 s ealth an n 27 is er frau		Catherleen Pinson	*		eech Par		ol Heig		207	
e,	- I I I		20a. Method of Disposition		b. Place of Dispos cemetery, crem		,	Date	20c. Location -		
DO.	Pages nent of unt: If its ary or o		1 Buriei 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	cometery, crem			June 9	Pitts	hurah	DΛ
altimore,	世界五年 中		21. Signature of Funeral Service License				ss of Facility LAT				
ñ	Dep limps	g	* Barne Dat	t. 1 ().1			ve., NW, Wa		/ 220 A	uburn	St.
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the d	eath. Do not ente	r the mode of dyli	ng, such as cardiac o	or respiratory a	Pitts rrest,	burgh	Approximate
	Physician /Medical Examiner		Immediate Cause (Finei disease or condition resulting in death)	Mali	gnant Ly	mphoma M	etastasis	_			nterval Between Onset and Death
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	outed nd ransit	Examiner	Sequentially list conditions)	o (or es a consequ			-			
o,	e exe lan al uriel-t		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury								
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Ø X											
Box	deeth certifi e ettending ed for use es	lan									
o.	es that the deeth certifi igned by the ettending be deteched for use ea	Physician/M	Part II. Other significant conditions con	tributing to death but not	resulting in the un	derlying cause giv	ven in Part I.			ntribute to	the cause of death?
٥.	thet the by detect							1 🗆	Yes 2 No	3 Probe	ibly 4 Unknown
Records,	been s	Completed by							an autopsy med?	evei	e autopsy findings iable prior to pletion of cause eath?
	The lew ate has to page 2 s	ma						10	Yes 2X No		Yes 2□ No
Viita	delan: The certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Death				160 2010
>		ToB	examiner?	lospital:	2 ☐ ER/Outpetient	3□ DOA Oth				er (Specify)	
on of	Attending Physic death. actor: After this by the funeral d		27. Menner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year	28b. Time of Injury	28c. Injui Wol			now injury occur		-J 14 73
Division	efter death. Director: A	Certification:	3 Sulcide 6 Could not be determined	28e. Piece of Injury - A building, etc. (Spe	t home, farm, stre	et, factory, office		281. Location (S City or Tox	Street and Numb vn, State)	er or Rural	Route Number,
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Phya 2 Medicat Examin	atctan: To the best of my ler: On the besis of examend manner steled.	knowiedge, death ination and/or inv	occurred at the tire	me, date end place, a ppinion, deeth occurr	and due to the ed at the time,	cause(s) and ma dete end plece,	inner as sta and due to I	ted. he cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	C. C.	/	29c. Licens	e number		29d. Dete signe	d (Month, D	ay, Year)
	- s - ō		kist. 1	10hna	M.D	Dad	274		June 1		
	(,		30. Name and eddress of person who con Kirti Vohra, MD		Item 23a) (Typa, F 99 La mbe	Print)		Silver	Spring,		
1	Sta Registr		31. Date filed (Month, Day, Yeer)	32. Registrer's Si	gnature	- , •			,		

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

					y.aa.	Certifica	ate of	Death	F	Reg. No.	21	341
	Dharaisia		1. Decedent's Neme (First, Middle, Las	t)					2. Date of Dea Month		Yaar	3. Time of Deeth
	Physicia /Medica		CONRAD RUDOLE	H SEIPPEL					July	10 19	998_	10:58 a.m.
	Examine	_	4e Facility Neme (If not institution, give	street end number)				4b. City, Town, or I				
			514 Dunkirk Rd.				der 1 Year	Baltimo		Balti		
	Funeral Director		5. Social Security Number 212-05-7218 Usuel Rasidence of Decedent	7. Age № 2□ F 9	(In yrs. last bii		ns Days		(Month, De)	7 Year) 16,1903	Birthpl Count Mary	lece (Stete or Foreign try) Land
	hend we	ŀ	10e. Steta 10b. County		10c. City, Tow	n or Location					10	0d. Inside City Limits
	Mary P-f sh	Ö	Maryland Baltimo	re	Balt	imore						1 ☐ Yes ZNo
	or 28	S. C.	10e. Street and Number			10f.	Zip Code			10g. Citizan of Wh	nat Coun	try?
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21215-0020	urs e	by Funeral Director	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Dacedent E Armed Forces? 1 ☐ Yes 2 X X N If Yes, Give Yeer or Detes:			cedent of pecify Cul	Hispenic Origin? (S pan, Mexican, Puart Specify:	pecify Yes or No- lo Rican, etc.)	14. Race Bleck Specify:	- America , White, o Wh:	etc.
5-0	72 ho	Completed	15. Decedent's Ed (Spacify only highast gre		16a	Decedent's U	suel Occu	petion during most of wor	rkina	16b. Kind of Bus	lnass/Ind	lustry
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12	be filed within tal Hygiene. d other than event, the We		17. Fathar's Neme (First, Middla, Last)		Г	urchasi	ng A	7	me (First, Middle,			riectife co
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aryl	should nd Mer marks umatic	0	19e. Informent's Name/Relationship (7		196	. Meiling Addre	ess (Stree	t and Number or Ru	rel Route Numbe	r, City or Town, S	tata, Zip	
	Health and Mer Health and Mer Ium 27 Is merke		Mr. William S. Vol	z Nephew	1.	2905 Du	ılane	y Valley	Rd. 2105	57		
Baltimore,	8 = 8		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☑ Donetion 5 ☐ Othar (Specify		Dete 7/13/98 E	20c. Location - C						
Balti	Department firmportant: I any injury o ance.		21. Abnature of Funeral Service Licen	an Ruge	bic			ess of Fecility 1-Wiedefe York Rd.	eld Home	Inc.		
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200	Physician /Medical Examiner	ler	Immediate Ceusa (Finet disease or condition resulting in death)	. /		audio	el,	ufaret				Onset end Deeth
x 68760,	ificeta be g physicia as the bur	9	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaasa or Injury that initiated avants resulting in deeth) Lest	C	Oue to (or as a							
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Bivision	Seath. tor: Alter the fune	Certification:	2 Accident investigation 3 Suicida 6 Could not be		and Atherma for	M]Yes 2□No	28f Location (5	Street end Numbe	r or Rug	I Route Number
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	State Registra		31. Dete filed (Month, Dey, Year) JUL 1 31	32. Registra	saignara Ma David	lson-Aand	المعد	-				



4b. City, Town, or Location of Death

11:15pm

4c. County of Death

Examiner

Physician

/Medical

NORA

7	-Autin		3403 MT. PLEASANT AVE.							BALTIMORE				N/A											
	Funeral Director	Completed by Funeral Director	5. Social Security N 217-24		ax □ M a⊋y	7. Aga (In yi 88	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Undar 2 Hours	4 Hrs. Min.	8. Data of Bi	rth ayy Year) 199	9. Birth	placa (S ntry)	itata or Foreign									
altimore, Maryland 21215-0020	2 3 S		Usual Residence of Decedent 10a, State 10b, County 10c City, Town or Location 10d Incide City Ltd																						
	be filed within 72 hours after deeth with the Maryland nat Hyglene. d other than "natural", or items 23a or 28a-f show event, it is Modical Experience must be notified as		10a. Stata 10b. County 10c. City, Town or Location MD N/A BALTIMORE											10d. Insida City Limits XIXYas 2□ No											
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			3403 M		21224				U.S.A.																
			11. Marital Status 1 □ Navar Marr 3 □ Widowed	12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Year or Datas:			13. Was Decedant of Hispanic Origin? (If Yes, specify Cuban, Maxican, Pua 1 ☐ Yas 2♥ No Specify:			n? (Spe Puarto f	city Yes or No Rican, atc.)	Bla	14. Race - Amarican Indian, Black, Whita, atc. Specify: WHITE												
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	should end Men is marke	-	19e. Informant's N	ame/Ralationship (Type, Print)		19b. Meili	ng Addrass	(Street	and Number	or Rura	Routa Numb	er, City or Town,	Stata, Zip	Code)										
	permit. Pages 1 and 2 should Department of Health end Mer Important: If Item 27 is marke any Injury or other traumatic QREs.		ANNA S	ISK/dau	ghter							AVE BALTIMORE, MD). 7	21224									
			20a. Mathod of Dis	Ramoval from Stata		. Placa of Disposition (Na cematary, cramatory or		a of har plac			Data	Data 20c. Location - City			y or Town, State										
			4 Donation			AK LAV			7	/11/98 BALTIMORE, MC				MD.											
Balt			21. Signature of Funaral Sarvica Licensee 22. Nama and Addrass of Facility CHARLES S. ZEILER & SON, INC.																						
	Physician /Medical		23a. Part1. Entoy the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heert feiture. List only one cause on each line. Immediate Cause (Final																						
	Examiner		disaase or condition rasulting in daath)	n	a	Stroke 6 mont									nonths										
	n =	ner	Dua to (or as a consequance of):																						
ivision of Vital Record	death certificate be becuted attending physicial end attending physicial end of for use es the bunal trensit	Physiclan/Medical Examiner																							
			that initiated events rasulting in death)	5	с	Dua to (or as a consequance of):																			
	eath certific attending pl	lan/			d																				
	t the de by the a	ysic	Part II. Other eignif	asulting In tha u	ulting In tha undarlying causa givan in Part I.				23b. Did tobacco use contribute to the cause of death?																
	es that the igned by th be detache	by Ph	Dem	entia								10	Yae 2 No	No 3 Probably 4 Unknow											
	e law requir has been s ge 2 should	Completed t										24a. Was perfo	an autopsy ormed?	av	raliabla p	opsy findings orior to n of causa									
		To Be										10	Yes 2 No	1[□Yes	20 No									
			25. Was casa rafar exeminar?	26. Placa of Death (Check only ona)																					
	99		1 □ Yas 200 No		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Otha					4 Nursing Homa 5 th Hasidan			dance 8 □Oth	nce 8 Other (Specify)											
	Attending P r death. ector: After t by the funer	ation:	27. Mannar of Death 1 Natural 2 Accidant 5 Panding Invastigation		28a. Data of Injury (Month, Dey Year) 28b. Tima of Injury			M 28	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No			28d. Dascribe how Injury occurred													
	いいまる	edical Certification:	3 ☐ Suicida 4 ☐ Homicide	8 Could not be datarminad	28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Route Number building, atc. (Spacify)								Numbar,												
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by		29a. Cartifier (Check only one) 1 Certifying Phye(clan: To the best of my knowladge, death occurred at the time, deta and place, and due to the causa(s) and mannar as stated. 2 Medical Examínar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the causa(s) and mannar as stated.													u se (s)									
	Fo the	Me	29b. Signatura and	titla of certifiar	0			29c.	Licens	a number			29d. Data signe	d (Month,	29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year)										

MD51964

30. Nema and address of person who completed causa of death (Itam 23e) (Typa, Print) Allison B. Evans, MD
Baltimure Medical System, 3501 Sinclair Lane, Balt. MD 21213

Dallim B. Evans, MD

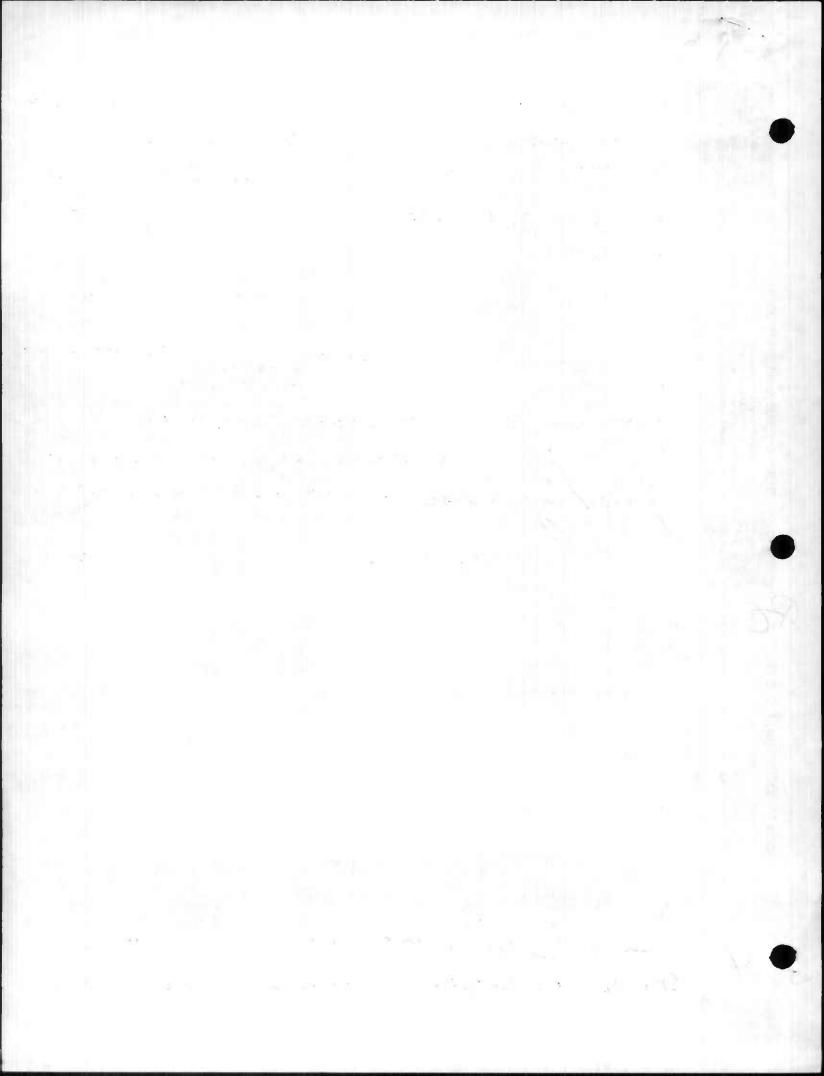
State Registrar

7.5

State of Maryland / Department of Health and Mental Hygiene

		(Certificate of	Death		Reg. No.	21	343					
hysician	Decedent's Name (First, Middle, Last)		1 11		2. Date of Dec		Annual Control	3. Time of Death					
ysician Medical	Lewis Cordova Smith				July	ff, 19		1:00 PM					
aminer	4a Facility Name (If not institution, give street and number	")		4b. City, Town, or L									
	Holy Cross Hospital		day) If Under 1 Year	Silver S			gomery						
l r	525-52-5037 ¼ M 2□F	ge (In yrs. last birth	Months Days	Hours Min.	8. Date of Bir (Month, Da July 1,	7, Year) 1932	Country	N.M.					
	Usual Residenca of Decedent 10a. State 10b. County	10c. City, Town	or Location				100	d. Inside City Limits					
5	MD Prince Georges	Lanhan				1X Yes 2 No							
Funeral Director	10e. Street and Number 5911 Justina Dr.		10f. Zip Code 20706			t0g. Citizen of W	/hat Country	13					
eral		t Fuer in II C		Hannaia Osigin? (S)	positu Voe or No		- American	Indian					
by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceden Armed Force 1 Yes, 2 Married It Yes, Give Year or Dates	? I No	13. Was Decedent of H If Yes, specify Cubin 1 Yes 2 □ No		Rican, etc.)	Specify:	k, White, etc	c.					
sted	15. Decedent's Education (Specify only highest grade completed)	16a. I	Decedent's Usual Occup Give kind of work done	oation during most of wor	king	16b. Kind of Bu	sinass/Indu	stry					
Completed	Elementary/Secondary (0-12) College (1-40)		life. DO NOT use retire	d)		II C	Dont	of More					
3	4		Archite		o (First Addu-			of Navy					
To Be	17. Father's Name (First, Middle, Last) Lewis Smith			18. Mother's Nam	ila Cord		Θ)						
	19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street				State, Zip C	iode)					
	Judith M. Smith - Wife		11 Justina				-						
	20a. Method of Disposition ✓ Burial 2 □ Cremation 3 ☑ Removal from Stat	9	Disposition (Name of , crematory or other pla		Date	20c. Location -							
	4 ☐ Donation 5 ☐ Other (Specify)	Nationa	al Memorial	Park	7.15.98	Falls	Churc	ch, VA					
	22. Name and Address of Facility Green Funeral Home, 721 Elden St., Herndon, V. Approximate 22. Name and Address of Facility Green Funeral Home, 721 Elden St., Herndon, V. Approximate Approximate												
Examiner	Immediate Cause (Final disease or condition resulting in death)	dial Infa						nterval Between Onset and Death DME					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	(or as a consequence of):										
redical	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	insequence of):										
N N	d						1						
sici	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause given	ven in Part I.	23b. Did	tobacco use cor	ntribute to t	the cause of death?					
by Physician/M					10	Yee 2□ No	3 Probe	ably 4 Unknown					
					24a. Was	an autopsy	avail	e autopsy findings lable prior to					
Completed					point		com	pletion of cause eath?					
5					10	Yes 2 No	10	Yes 2□ No					
	25. Was case referred to medical			26. Place of Dea	ath (Check only	one)							
	examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpa	tient 2 KER/Out	patient 3 DOA Ott	her		denca 6 □Oth	er (Specify)						
	27. Manner of Death 28a. Date of In		me of 28c. Inju			how Injury occur							
	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 No	28f. Location (Street and Numb	er or Rural	Route Number,					
	4 LI Homicide building,	etc. (Specify)			City or To	wn, State)							
edical	29a. Certifier (Check only one) 1 Certifying Phyelcian: To the best 2 Medical Examiner: On the basis and manner.	of examination and	death occurred at the ti for investigation, in my o	me, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and ma date and place,	anner as sta and due to t	ted. he cause(s)					
Σ	29b. Signature and title of certifler	- DI	29c. Licens DO04			July 1		The second					
	20 Nome and address of	doub /him on a		**************************************			-						
	30. Name and address of person who completed cause of	Death (Item 238) (1	2101 Medic	al Dark	Dr - C:1	War Cn-	ina 1	MD 20902					
21.5	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	aror rieuro	ar ralk	עני, איני	ver phr	mig, l	.IIJ 20902					
tate trar	JUL 131998		n-Randell										
0.5	QOL T 0 1330	Indian											

Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** SWOTTH lune 1998 /Medical 4b. City, Town, or Location of Death **Examiner** tospital (e 7. Ago (in yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 12 M 2 F 212-12-726 Director 76 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. tnside City Limits Baltimore saltimore Count 1 ☐ Yes 2 No Maryland Directo herm 23s or 28e-f ner must be notifie 10e. Street and Number 10g. Citizen of What Country? 2/237 13. Was Decedent of Hispanic Origin? (Specify Yas or Noif Yes, specify Cuben, Mexicen, Puerto Rican, etc.) U. S. 8106 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 M Yes 2 □ No If Yes, Give 14. Race - Amarican Indian, 11. Marital Stetus Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or its 1 Never Married 2 Merried 1 ☐ Yes 2 No altimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Year or Datas: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown 17. Fether's Neme (First, Middle, Last) 16. Mother's Neme (First, Middle, Malden Sumame) Be Smith Marie Harry 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Steta, Zip Code) Baltimore Maryland 21237 Dete 200. Location City or Town, State mildred Wife 8106 21/0 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition b 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Donetion 5 ☑ Other (Specify) in state 21. Signeture of Funeral Service Licentus Joseph 22. Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street Van Sant Baltimore, Maryland 21201 Inter the disease, of complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Daath Physician . Acute Myocardial Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last gug Division of Vital Records, P.O. Box 68760, Physician/Medical the Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 90 24b. Were autopsy tindings available prior to completion of ceuse of deeth? 24a. Was an autopsy Completed Hyperlipidemia page 2 2 No 1 Yes 2 No 1 Yes certificate To the Hospital or Atlanding Physician: within 24 hours after death. To the Funeral Director: After this carlification placetary filled in by the funeral director; it Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 26a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Tima of Certification: 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 26f. Location (Street end Number or Rural Routa Number, City or Town, State) 4 THomicide odical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier 29d. Dete signed (Month, Day, Year) 29b. Signature and the #f certifie 29c. License number

Franklin Square Drive Baltimore, MD 21237

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Aegistra & Signature Panda

31. Dete filed (Month, Day, Year)

JUL 13 1998

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #28b Per MEO Film G761 7-16-98RC Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day **Physician** William Henry Sellman, Jr. 10:15 PM July 8, 1998 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Multi Medical Genesis Eldercare Center Towson Baltimore If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1 3M 2 F Months Days Director 220-36-2096 58 April 9,1940 Maryland Usual Residence of Deceden the Maryland 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Dundalk 1 Yes XX No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7511 Westfield Road 21222 United States Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

It if item 27 is marked other than "natural", or item in yor other traumatic event, the Medical Examine in yor other traumatic event, the Medical Examine. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Years Longshoreman Shipping Industry 18. Mother's Neme (First, Middle, Malden Surneme) 17. Fathar's Name (First, Middle, Last) Be Charlotte Scriven William H. Sellman, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7511 Westfield Road Dundalk, Maryland Mrs, Rhoda M. Sellman/Wife 20b. Placa of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Ramoval from Stata permit. Page Department of Important: If any Injury or once. Meadowridge Mem. Park 7/11/1998 4 ☐ Donation 5 ☐ Other (Specify) Dorsey, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Dundalk, Maryland Approximate Interval Between Onset and Death **Physician** Machine or memory principle /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): physician and the death certificate be a Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy tindings available prior to completion of causa of deeth? 24a. Was an autopsy performed? Completed has 1 Yes 2 No funeral director Be 25. Wes casa reterred to medical examiner?

17 Yes 2 No 26. Placa of Death (Check only one) Hospital: 1 | Inpetient 2 | ER/Outpetient 3 | DOA Other: 2 Nursing Home 5 Residence 6 Other (Specify) this anner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury Work 28d. Describe how Injury occ Certification: 28b. Time of After 5 Pending Investigation ☐ Natura! I or Attending after death. Director: Aft 2 No 2 Accident UNK. 6 Could not be determined 3 Sulcide farm, street, factory, of 4 Homicide 24 hours The Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Within 2 To the

Registrar

29b. Signatura and title

30. Name and

Dr.

Alan Shorofsky 515 Fairmount Ave. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

of person who completed cause

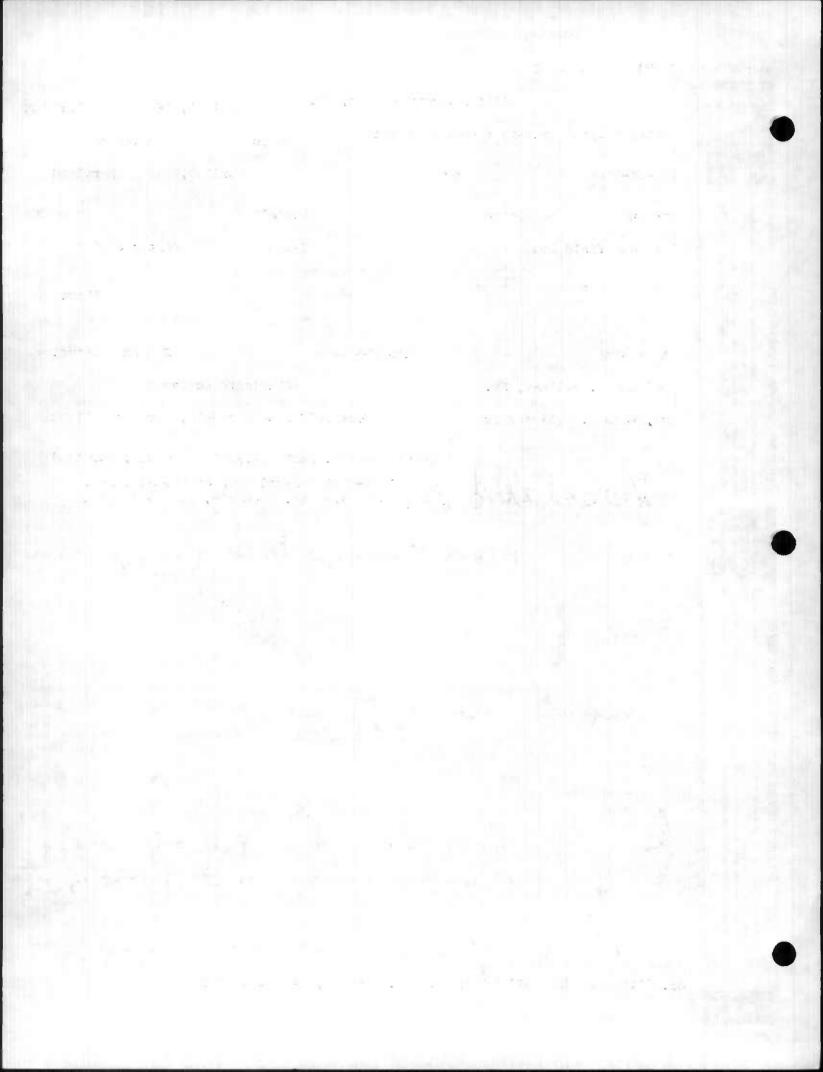
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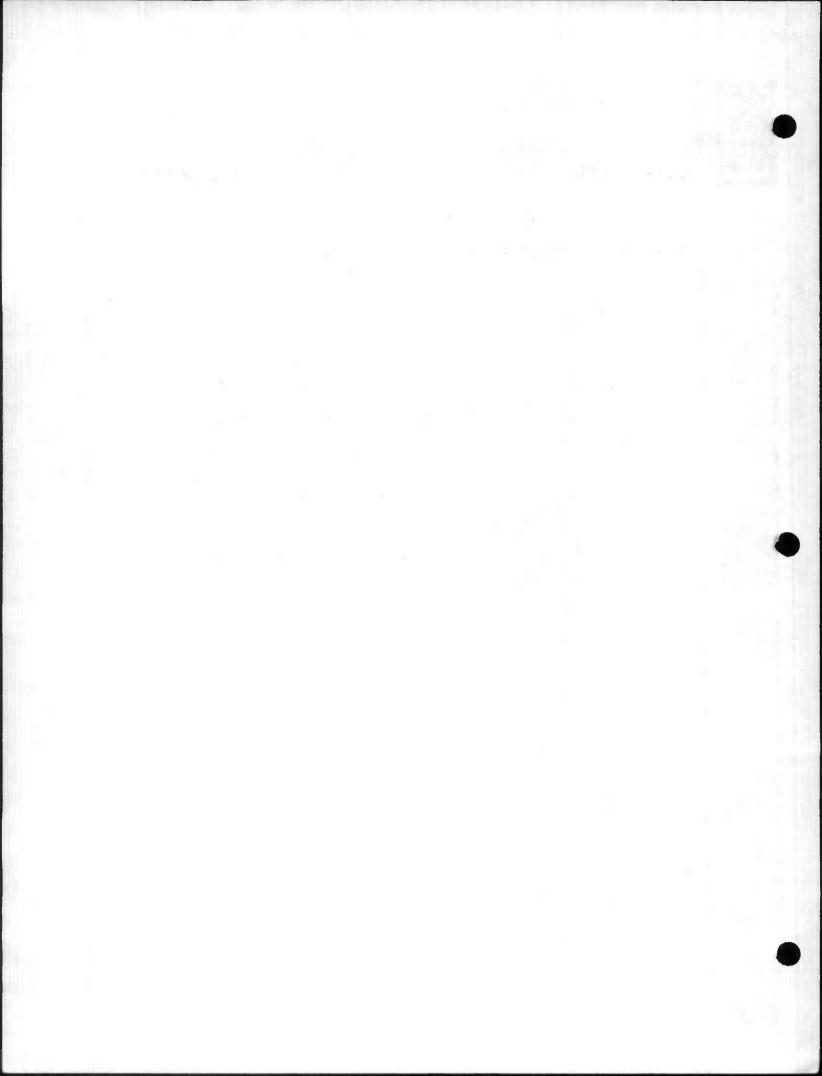
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				Ce	rtificate o	f Death		Reg	. No.	6	1040	
I	Physician	Decedent's Name (First, Middle, Last,	Patricia	Steir	nert			Date of Death Month	Dey	Year	3. Time of Dea	
٩,	/Medical	4a Facility Name (If not institution, give	etreet and number)			4h City Ton	wn, or Locatio	JULY o of Death	10, 1 4c. County		1:50 A	JM_
	Examiner	Saint Joseph N			imore							
	Funeral Director	5. Social Security Number 6. Security Number 212-34-7343	7. Age (In yrs. 62	last birthday, Yrs.	If Under 1 Yes Months Day		Min. (8. Date of Birth (Month, Day, Year) 9. Birthplaca (S. Country) Feb. 14,1936 Marylan				reign
	P Bu	10a, State 10b. County	10c. City	, Town or L	ocation					10	0d. Inside City Li	imits
	or 28a-f show be notified at Director		timore				ndalk				1 ☐ Yes 2 🕅	₫ No
	# 0M D	10e. Street and Number 7906 St. Bridget	Lane		10f. Zip Code	21222		U	nited			
020	un sher de af, or ham Examiner. by Fune	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	S. 13.	Wes Decedent of If Yes, specify Co		gin? (Specify , Puerto Ricar	Yes or No- n, etc.)		e - America k, White, e		
5.0	72 h nahu dical	15. Decedent's Edu (Specify only highest grad		16a. Dece (Give	dent's Usuel Occ kind of work dor DO NOT use reti	upation ne during most	of working	16	b. Kind of Bu	sinass/Ind	ustry	
Maryland 21215-0020	ed within 72 ho ygiene. er then "naturn 4, the Medical Completed	Elementary/Secondary (0-12) 8 Years	College (1-4or 5+)	life.	Housewi:				Own Ho	me		
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ylai	Mentito affice affice	Albion Treadwell				Ev	elyn I	ouise	Efford	l		
	and 2 sho path and 5 27 is m or traum	19a. Informant's Name/Reletionship (Ty Mr. Herman E. Ste		1000	of St. Br:						Code) 21222	
Baltimore,	Pages 1.1 nant of He my or othe	20a. Method of Disposition 1 Surial 2 Cremetion 3 4 Donation 5 Other (Specify)	lemovel from State	emetery, cre	osition (Name of matory or other p of Faith				c.Location - Baltin		wn, State Marylar	nd
Balt	Departs Departs Imports any inju	21. Signature of Americal Survice License	F. KI	I	2. Name and Add	k Funer	al Hom					
	Dhuaialaa	23a. Pert1. Enter the disease, or complishock, or heart failure. List only or	nations that clused the deeth	n. Do not en	1922 Wise	lying, such es	Dunda cardiac or res	1k, Ma piratory erres	ryland L	21:	Approximata Interval Batweer Onset and Deat	n th
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Records	aw requi						_ [24a. Was an performe		878	ere autopsy findir allable prior to mpletion of cause deeth?	
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of Vital	yalclen: The secreticate director, pag	25. Was case referred to medical examiner?					of Death (Ch	eck only one)				
7	5 0 0 0	1 ☐ Yes 2 2 No		ER/Outpatie	ווו שטטטרן			5 Residen			1)	
	Attending Ph ordesth. ector: Atter th by the funeral	27. Manner of Death 1 ANeturet 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Tima o Injury	V	juryat vork? □Yes 2□I		Describe how	injury occuri	red		
Division	her din by	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		reet, factory, offic	Xe .		Location (Stre City or Town,		er or Rura	l Route Number,	
	To the Hospital within 24 hours To the Funeral Completely filled	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	nician: To the best of my knowner: On the basis of examiner and manner stated.	wledge, deat ion and/or in	h occurred at the ivestigation, in m	tima, data and y opinion, deal	d place, and d th occurred al	fue to the cau the time, date	se(s) and me e and place,	enner es st and dua to	ated. the cause(s)	
	within To the compl	29b. Signeture and title of continer	0 10		29c. Lice	nse number		290	t. Det signe	d (Month, I	Day, Year)	
	,	1 (moth	fow Mil			034			7/10	198		
	6	30. Name and addrass of person who co TIMOTHY LOW, M.	mpleted cause of death (Item D., 7620 YO			WSON,	MARY	LAND	2120	4		
	State	31. Data filed (Month, Day, Year)	32 Registrare Signa	on Rand	202							

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	hysici: /Medic		Decedent's Neme (First, Middle, La Brad Courtney St	•					2. Dete of De Month	Dey		200 AM	
Fü	Examin Ineral rector	-		Ral Hos	pita	last birthday) If Ut Yrs. Mon	nder 1 Yaer	4b. City, Town, o		n/a	9. Birthpleca	a (Stete or Foreig	
lenyland	notified at	J.	10e. Stete 10b. County	n/a	1	y, Town or Location 1timore						Inside City Limits	
with the N	23a or 28a-f	Funeral Director	10e. Street end Number 1111 Park Avenue	Apt. 3			Zip Code 212	01	10g. Citizen of Whet Country?				
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of 2 should be file th and Mental Hy	irked other itic svent,	To Be	17. Fether's Neme (First, Middle, Last Clarence C. Smith		ame (First, Middle es Shorte		10)						
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oral timore, emit. Pages 1 at Separtment of Hea	important: If flem 27 is marked other any injury or other traumatic svent, once.		20a. Method of Disposition 1 Buriei 2 Cremation 3 4 Donetlon 5 Other (Specie		C	lece of Disposition amatary, cremetory utus Memo	or other ple	July 7	20c. Location - City or Town, State Baltimore, Md.				
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hat the	signed by the after id be detached for t	y Physician/M	Pert II. Other eignificent conditions o	ven in Pert I.	23b. Did tobacco usa contribu			./					
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5			30. Name and address of person who Elisa Gil,	m.n.	leeth (Item	23a) (Type, Print) Parylan	d 6	enera	e Hos	pita	2		

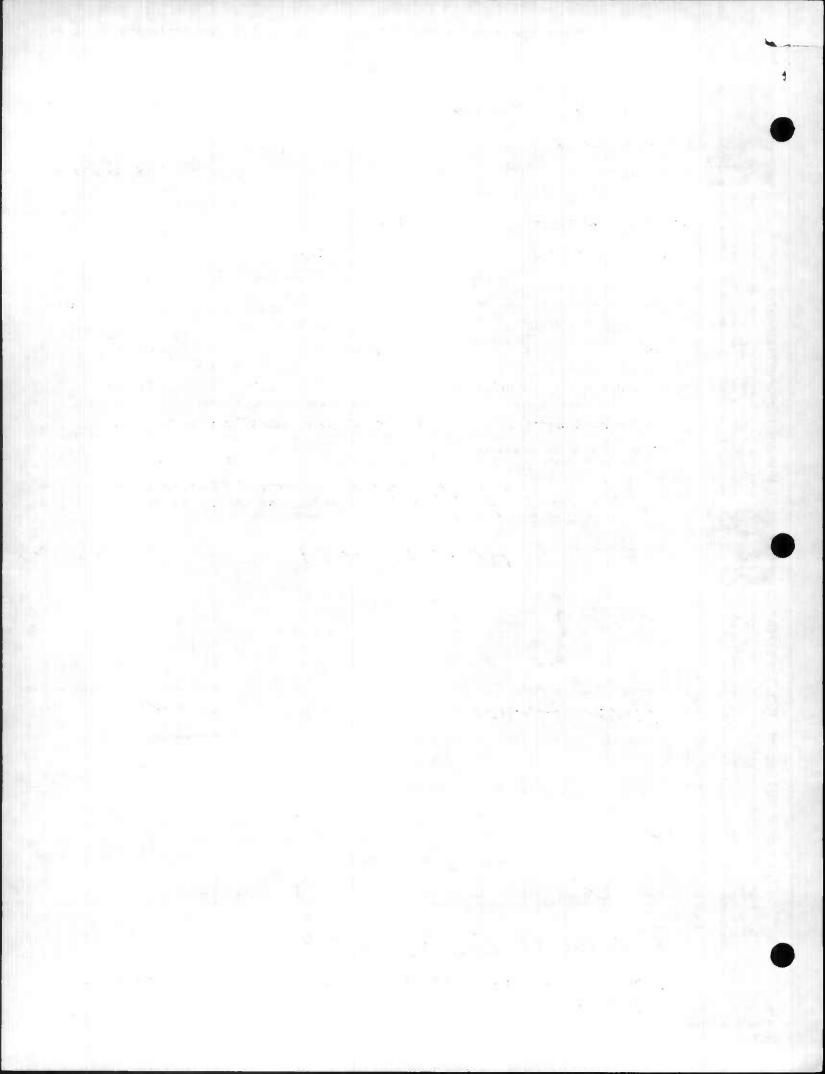


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 1. Decedant's Name (First, Middle, Last) 3. Time of Deeth Month **Physician** July 10, 1998 Katherine A. Simermeyer 9:15 P.M. /Medical 4b. City, Town, or Location of Deeth 4c County of Death 4a Facility Neme (If not institution, giva street and number) Examiner Genesis Eldercare Randallstown
If Undar 1 Yaar If Undar 24 Hrs. 8. Date of Birl
Months Days Hours Min. (Month, Da Baltimore 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) 8. Date of Birth **Funeral** Days Hours 1 ☐ M 2 🔀 F Yrs. Director 060-52-1634 100 March 12, 1898 New York Usual Residence of Decedant with the Maryland 10e. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ₺ No Directo Maryland Baltimore Randallstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9109 Liberty Road 21133 U.S.A. Funeral death 12. Was Decadant Evar in U,S. Armad Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 ☒ No if Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married 1 Yas 2 No Specify: P 3 ₩ Widowed 4 Divorced White Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16h Kind of Business/Industry Yonkers New York Elementary/Secondary (0-12) College (1-4or 5+) 12 School School District Teacher 18. Mothar's Nama (First, Middla, Maidan Sumame) 17. Fathar's Nama (First, Middla, Last) John Keefe Annie Cotter 19a. informant's Nama/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Ia m any injury or other traum 1 Burr Oak Court Randallstown, MD 21133 Mr. Arthur Simermeyer 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Holy Family Cemetery Randallstown, MD 7/16 21. Signatura of Funerai Sarvice Licenses 22. Nama and Address of Facility any ir Loring Byers Funeral Directors, Inc. 23a. Part1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such es cardiec or raspiratory arrast, shock, or heer failure. List only one cause on each line. nolins Randallstown, MD 21133 Approximata intervel Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medicai Examiner Dua to (or as a consequence of) Physician/Medical Examiner Sequantially fist conditions, if eny, leeding to immediata causa. Entar Undarlying Cause (Disaase or Injury that initiated events rasulting in deeth) Last Dua to (or as a consequence of) Box 68760 physician law requires that the death certificate Due to (or es a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to should 24a. Was an autopsy performed? Completed complation of cause of death? page 2 certificate has The 20 No Division of Vital Physician: 25. Was casa raferred to medical examinar? Be 26. Placa of Death (Check only one) Hospitel: Othar: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yas 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA in 24 hours after death.

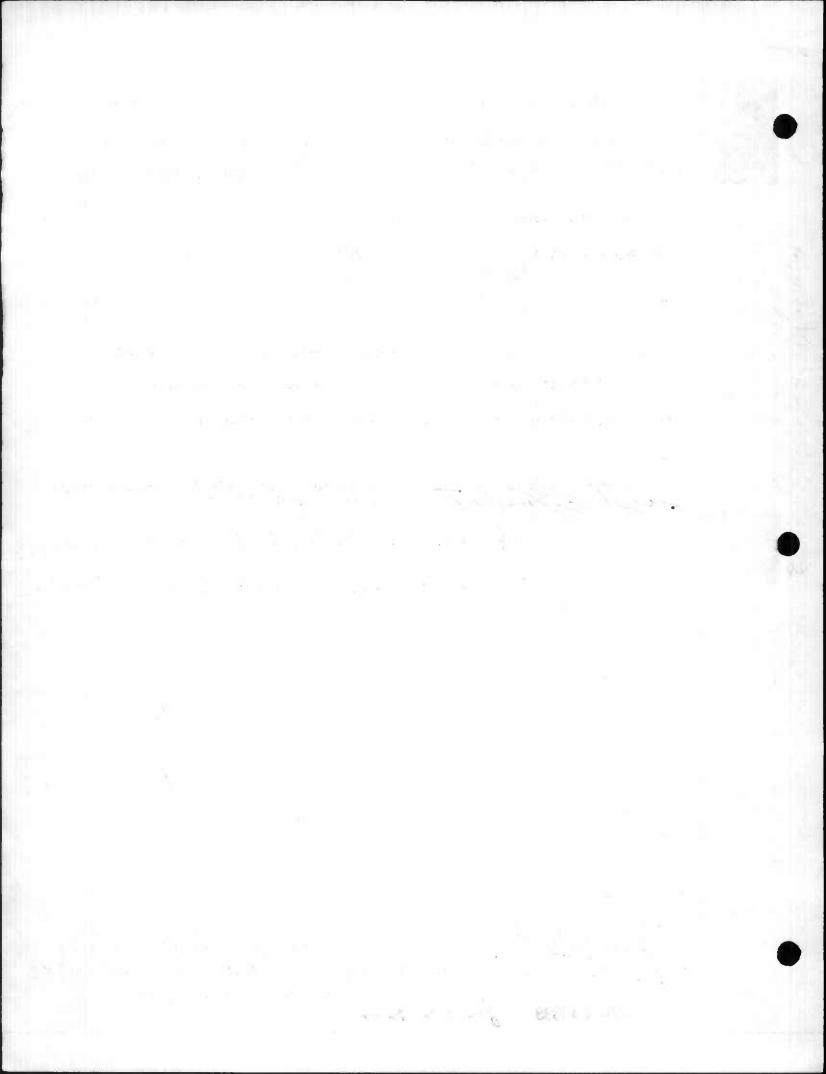
Ne Funeral Director: After this of the funeral displayed in by the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the funeral displayed in the fun this 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Tima of Certification: 28c. fnjury at Work? or Attending 5 Pending Invastigation 1 TYes 2 No 2 Accidant 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, dete and placa, and dua to tha causa(s) and mannar es steted. edical (Check only one) 2 Madical Examiner: On the basis of examination and/or Invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and manner stated. within 2 29b. Signature and Jiffing! certifia 29c. Licensa number 29d. Deta signed (Month, Day, Year) 0 July 13, 1998 D20964 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) M.D., 8630 Liberty Plaza Mall, Randallstown, MD Ginsberg, Jerome H. Registrar's Signature State

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 0550 P.M **Physician** Norma Priscilla Stevens 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of North Arundel Glen Burnie Anne Arundel 7. Age (In yrs. last birthday). If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Days 220-09-5793 1 M 2 X F Months Hours Oct. 3, 1919 **Director** New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Medical Examiner must be notified at Director Maryland Anne Arundel 1 ☐ Yas 2 ☑ No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 313 Hospital Drive therms 23a 21061 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X natural, or 1 ☐ Yes 2 TNo Specify: Specify: White 3 Widowed 4 Divorced Yeer or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Buainess/Industry Elementary/Secondary (0-12) College (1-4or 5+) Keypunch Operator Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Health and Mental Wilfred Ernest Veira is marked Mira Marie McCutcheon 2 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Edward Earl Perkins, Jr. 1213 Royal Oak Drive, Dunedin, Florida 34698 mportant: If item 27 20b. Placa of Disposition (Neme of 20e. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other piece) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph B. Van 22. Name and Address of Fecility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23. Part. Efter the disease, or complications that caused the deeth. shock, or heart failure. List only one ceuse on each line. Do not enter the mode of dying, such es cardiec or respiretory errest, Approximate Interval Between Onset and Death ARTERY DISEASE Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner HYPERTENSION 3Y FARS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760 ž Physician/Medical at initiated events sulting in death) Last The law requires that the death certificate 2 Due to (or as a consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 23b. Did tobacco usa contributa to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes ģ 2 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 差 page 2 1 Tes ata: 1 Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Albar Attending 5 Pending 1 Natural death. 1 Yes 2 No 2 Accident investigation if or Attand after death Director: / 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29e. Certifier 29b. Sidentale and title of certifler July 07, 1998 29c. License number 14160 Signeture MARY LAND-21225. 32. Registrer's Signeture 31. Date filed (Month, Dey, Year) State JUL 1 3 1998 whia Davidson Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1415 July IROSKA - BAOK /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street end number) 4c. County of Deeth **Examiner** HOSPITAL IORIAL 5. Social Security Number 124 BALTIMORE If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) Funeral Months **⊅8**3 M 2□ F Yrs. JUN 3, 1923 Director 191 32 8385 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner mast be notified at 1 ☐ Yes 2 No Director BALTIMORS ARKVILLE MARYLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 3406 AC 101 21234 KOAO U-S.A death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Heelin and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Market on the Market on the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market of the Market 1 Never Married Married 1 ☐ Yes 25 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) Las Technician JOHNS HOPKINS 12 YRS SYRS. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) FRANK 1 ROSKA (ARIA 1 ROSKA 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21034 DIEGLER LOURT ROBERT D. TROSKA 3202 JARRETTIVILLE MARYLAND 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition Dete 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removel from State 10711 PARKVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD LIMITERY 1348 21. Signature of Funeral Sarvice License 22. Name end Address of Fecility Memoriss 4/06/16 PARKINE MARVLAND 8300 HARFORD (2000) 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Final · Multiorgan Failure 24 Itours disease or condition resulting in death) Examiner Examiner the buriel transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detach. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Renal Failure Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed Congestive Heart Failure Artery Coronary 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpetient 3 DOA 9 this filled in by the funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: After 1 OMatural 5 Pending Investigation i or Attending s efter death. il Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Hospital c To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piace, and due to the cause(s) and manner steted. 29a. Certifier Medicai (Check only one) 29b. Signeture and title of certifier

29c. License number

E. University PKWay

AT 2438946

29d. Date signed (Month, Dey, Yeer)

July 8, 1 Baltimore

muryland

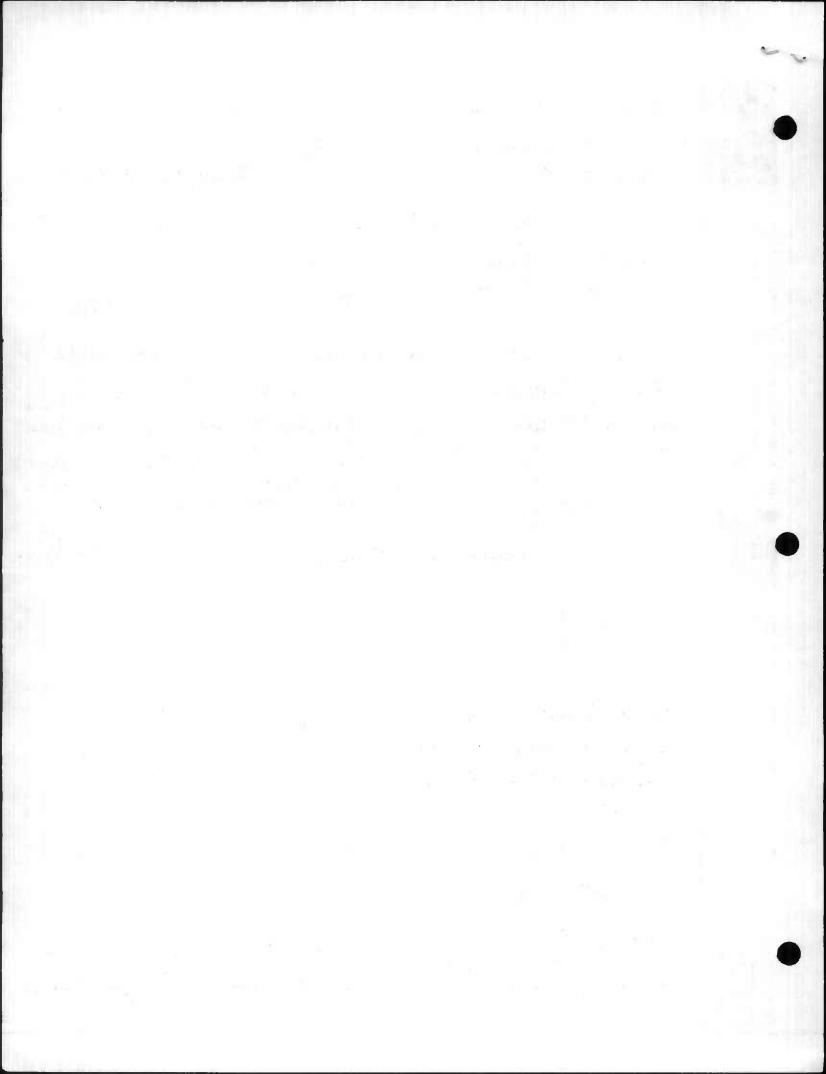
State Registrar 30. Name end address of person who completed cause of death (tem 23e) (Type, Print)

orsev

32. Hegistran Signatur Junia Davidson-Randall

nthony

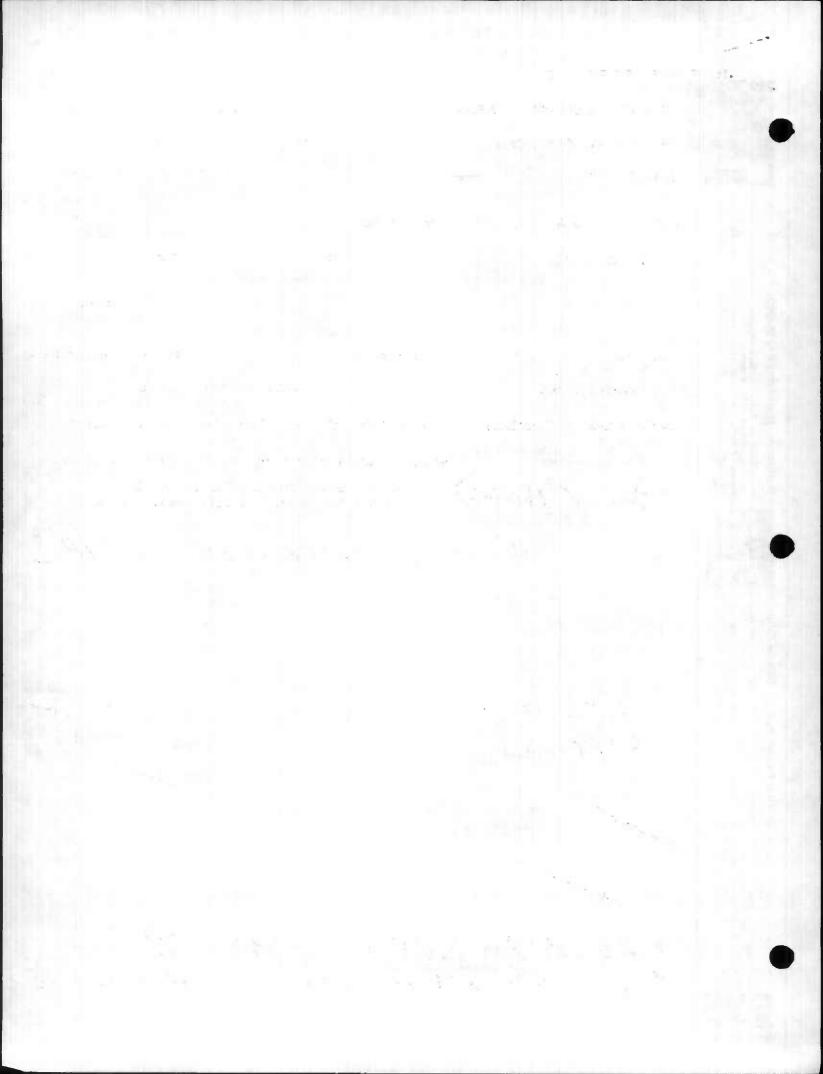
31. Dete filed (Month, Dey Jear)
JUL 1 3 1998



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death -Item#7 per FH G761 7/13/98 EW 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** July 9, 1998 4:05 AM VALERIE KATHLEEN THOMPSON /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Genesis Elder Care Randallstown If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Deys Months 1 □ M 2 ☑ F Yrs. 42 July 9, 1956 **Director** Maryland 213-68-7628 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10e State 10b. County 10c. City, Town or Location Show Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 23a-f show ury or other traumatic event, the Modical Examiner must be notified as 1 Yes 2 □ No Directo Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5112 Belair Rd. 21206 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Biack, White, etc. 1 Never Married 253 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) American Legion Hall 10 years Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iris Winifred Parker Alexander Oakes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jarrettsville, MD (Brother) 1804 Twin Oaks Rd. David Oakes 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If any Injury or DOCS. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Washington Crem 7-11-98 Laurel, Maryland 21 Signature of Funeral Service Licenses 22. Name and Address of Fecility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, Maryland 21133 23a. Pany Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, and or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final ALCOHOLIC LIVEN FAILURE diseese or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of) 65 esn signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed RRHOSI certificate has b lirector, page 2 s 1□ Yes 21 H 1 ☐ Yas 2 ☐ No 25. Was cese referred to medicel exeminer? Be 28. Place of Death (Check only one) Hospitai: Other: Nursing Home 5 Residence 6 Other (Specify) 2 1□ Yes 2□ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27, Manner of Dear 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After Nature or Attending 5 Pending 1 Yes 2 No death. Investigation s after ocean Director: P 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Homicide filled in 24 hours a Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner es stated 29a. Certifier edical To the Hosp within 24 hor To the Fune completaly fi 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29d. Date stoned (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 38 GMEER THEE LOMICS 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 1 3 1998 helid Davidson Rando De

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Thomas rannette. Henrietta 1998 JULY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death THE JOHNS HOPKINS HOSPITAL Baltimore BALTIMORE CITY If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthdev) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Days Hours Months 1□ M 25 F 56 213-42-0070 March 10, 1942 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 □ No Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4306 Fairview Avenue 21216 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status 1 TX Never Married 2 ☐ Married 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College 5+ Professor 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Joseph John Raymond Thomas Agnes Mills 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 7954 Old Falls Road, McLean, Virginia 22102 Burton Johnson/nephew 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State stery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 (Specify) 21. Signature of Funeral Service Licensee Joseph B 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death art. Enter the disease, of com-nock, or heart failure. List only Immediate Cause (Final sepsis disease or condition resulting in death) Myelogenous Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 28 No 1 TVes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 1 5 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical

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Certification:

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amili. Pages 1 and 2 should be filed within 72 hours after on Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

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death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions o that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28d. Describe how injury occurred

1 Yes 27. Maryner of Death 1 SaNatural

5 Pending investigation

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)

28b. Time of

Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Street Baltimore

29a. Certifier (Check only

2 Accident 3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier

29c. License number

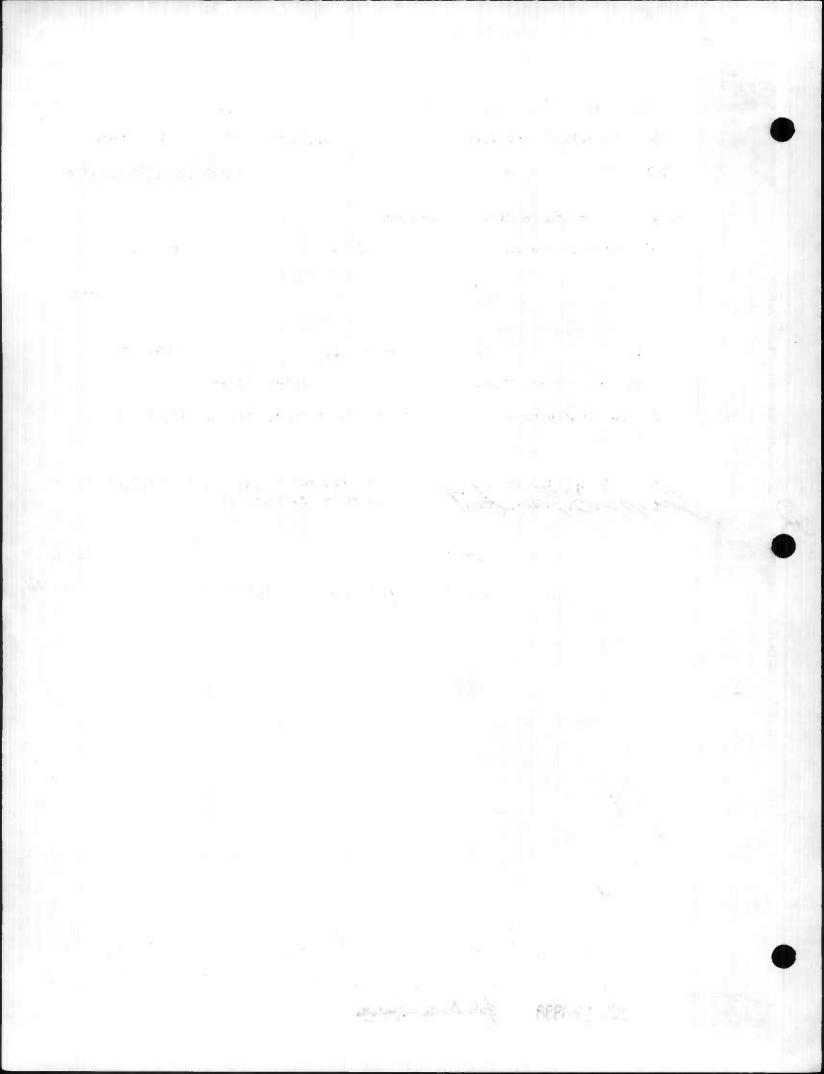
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
JUL 13 1998

Wolfe North 32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Wiggins 4b. City, Town, or Location of Death 4e. Fecility Nema (If not institution, give street and humb 4c. County of Daath 12altimoi Mealth a Himore DanVIEW 5. Sociel Security Number 7. Aga (In vrs. lest birthday) Yrs. If Undar 1 Yaar If Undar 24 Hrs. Birthpleca (Stata or Foreign Country) Days 1□ M 20 F 82-4687 Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Ballimore 1 Tes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21213 2008 U.S.A. North 12. Wes Decedant Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yas, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Home Coltege (1-4or 5+) OWN Elementery/Secondery (0-12) Care provider Child grade 12th 17. Fether's Neme First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Albert Mosley Brown NormA 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Bolling Rd, Batto, , MD Loretta 8107 Sagramore 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Locetion - City or Town, Stete Date 1 Buriel 2 Cramation 3 Removal from State 7-13-98 Dundalk; ushell mem Garden 4 Donetion & Other (Specify) 21. Signature of Funerel Service Lice 22. Neme end Address of Facility E. North Ave. 1101 GAST F. 4. March Enter the diseasa, of con-lor heart feilure. List only Do not enter tha mode of dying, such es cerdiec or respiretory errast, coused the Approximete Intervel Batween Onset end Deeth tmmediete Ceuse (Fine) PNEUMONIA disaasa or condition resulting in deeth) Due to (or es e consequence of): Sequentielly list conditions, if eny, teeding to immediate ceuse. Enter Underlying Ceuse (Disease or trijury that initiated events rasulting in death) Lest Due to (or es e consequence of): Due to (or es e consequença of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2N No 3 Probably 4 Unknown HUMAN IMMUDDEFCIENCY VIRUS INFECTION, ACQUIRED 24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? 24e. Wes an autopsy performed? IMMUNODERCIENCY SYNDROME, DIACYSIS DEPENDENT 1 Yes 2 No NETHOPATTY, CYTOMEGALOUINS INFECTION 25. Was case referred to medical exeminer? 1 ☐ Yas 26. Piece of Deeth (Check only one) 1 Yes 2€ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medicai Examiner

Physician

Examiner

Funeral

Director

28a-f show

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items 23a

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permit. Pages 1 and 2 should be flied within Department of Health and Mental Hygiane. Important: If item 27 is marked other than any injury or other traumatic event

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72 hours after

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records.

Division of Vital

Director

Funeral

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Completed

other traumatic event, the Medical Examiner must be notified at

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Examiner Physician/Medicai by Completed

29e. Certifier

31. Dete filed (Month, Dey, Yeer)

physician and the à signed be del To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, completely filled in by the funeral director, Be Certification: To

State Registrar

Medical

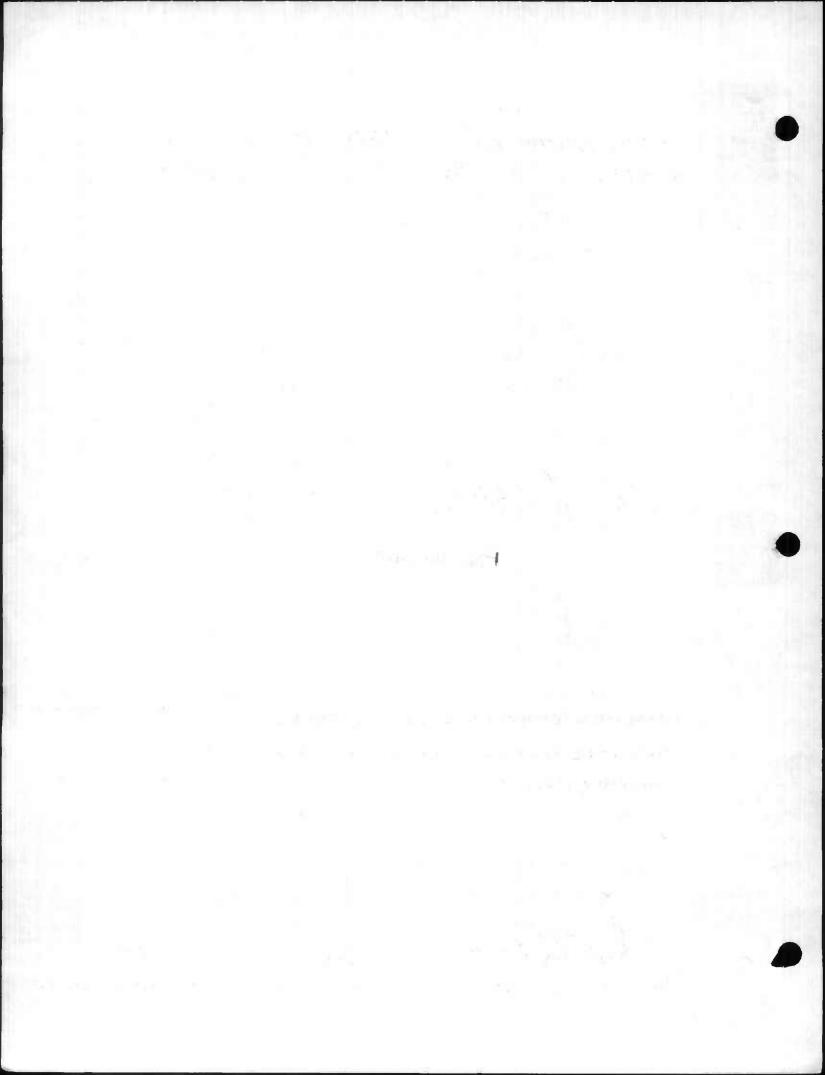
Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Neturet 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end ptece, end due to the ceuse(s) end menner stated. 29b. Signature and Itle of certifier 29c. License number

HRISTOPHER F. APPONTER MY NO05 1957

29d. Dete signed (Month, Day, Year)

eddress of person who completed cause of death (Item 23e) (Type, Print) 1830 EAST MOWHONE, SUITE YUZ, BAUMMAE, MD ZIZOS

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Items:1,27 per M.D G-761 7/13/98 reb 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Mqnth **Physician** WHARTON SARAH 400 AM Idela luw /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Church Home AND Hospital Baltimore City N/A If Undar 1 Yaar | If Undar 24 Hrs. Months Days Hours Min. 5. Social Sacurity Numbar 7. Aga (in yrs. last birthday) 6. Sax 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** 1□ M 2X F Days Yrs Director 219-30-8617 93 May 26, 1905 Maryland Usuei Residanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No Director 28a-f Maryland N/ABaltimore City 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ŏ 238 101 North Bond Street 21231 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ≥ ∑No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 40 PHYSICIAN 1 Navar Marriad 2 ☐ Married ò 1 ☐ Yas 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15 Decedant's Education 16b. Kind of Businass/Industry (Spacify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) Medical 4 yrs Registered Nurse 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maldan Surnama) Be Ira Colburne Wharton Mary J 19a. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) MAME Hern 27 Mrs. Catherine W. Noon, Sister 1549 E. Northern Parkway, Baltimore, MD 21239 20e. Mathod of Disposition 20b. Plece of Disposition (Nema of cematary, cramatory or other place) Dete 20c. Location - City or Town, Steta 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 7/7/98 Princess Anne, Maryland Andrew's Episc. Ch Marin Servin Line Insaa 21. Signatur 22. Nama and Addrass of Facility any i awsm 6500 York Road Martin D. Lawson 23e. Pert1. Entar tha disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List *only* one cause on each line. Approximata Intarval Betwaan Onsat and Daath **Physician** /Medicai Immadiata Ceuse (Final ERERRO - VASCULAR ACCIDENT disaasa or condition rasulting in daath) WEEKS Examiner Dua to (or as a consequence of): Examiner The law requires that the death cartificate be executed Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or Injury thet Initiated events rasulting in daeth) Last burial-trar Dua to (or as a consequence of): physician Physician/Medical the Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown by Completed 24b. Wara autopsy findings available prior to completion of causa of daeth? 24a. Was an autopsy performed? peen certificate 1 Yas 1 ☐ Yas 2 No Be 25. Was casa ratarred to madical axaminar? 26. Pieca of Daath (Check only ona) Hospital: 1 ☐ Yas 2 ☑ No Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 8 ☐ Other (Specify) Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28e. Data of Injury (Month, Dey Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After 5 Panding invastigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accidant

Records, P.O. Box 68760. Division of Vital Attending Physician: or Attendi after death. Director: A death. the filled in by Hospital 24 hours a 24 hours

3 Suicida 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifian

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner stated.

| Medical Examiner: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner stated.

29b. Signature and titla of certifler

Alos M D 46893

29c. Licensa number 29d. Data signed (Month, Day, Year)

30. Nema and address of person who complated cause of death (Item 23a) (Type, Print) C#VRC# HOLP ITAC HOME SARKOBEE - ABOO CLARENCE

State Registrar

Medical

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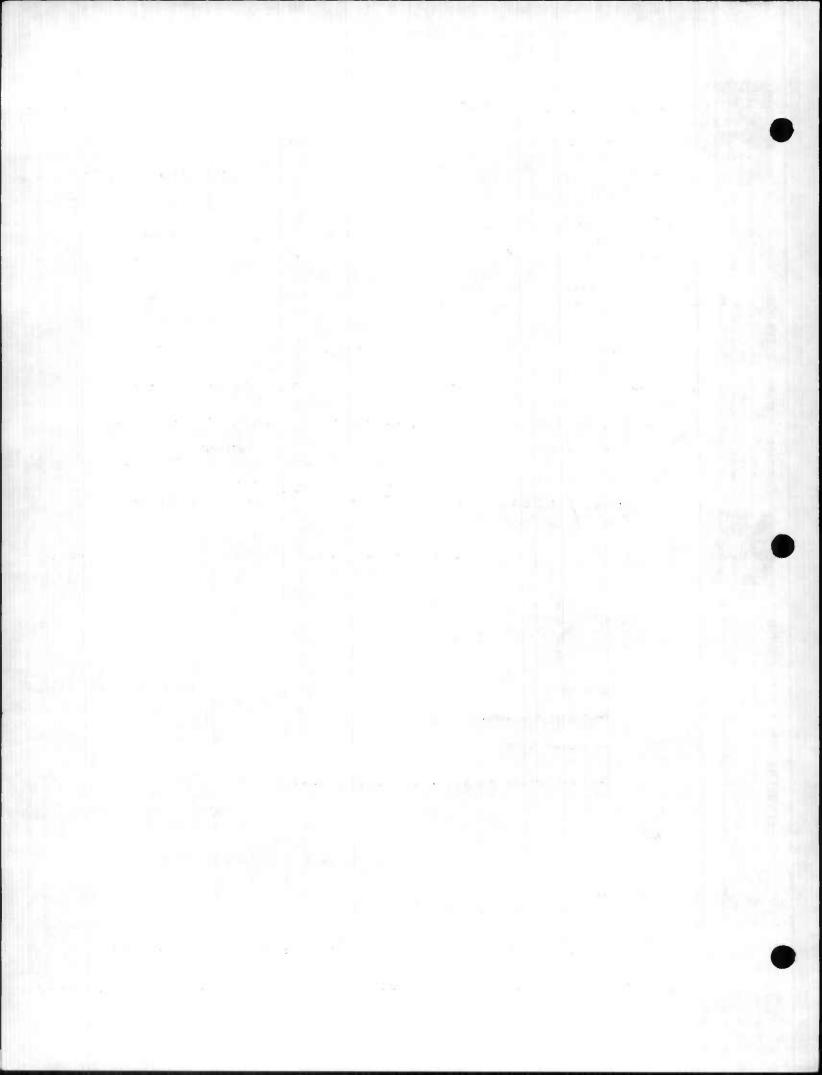
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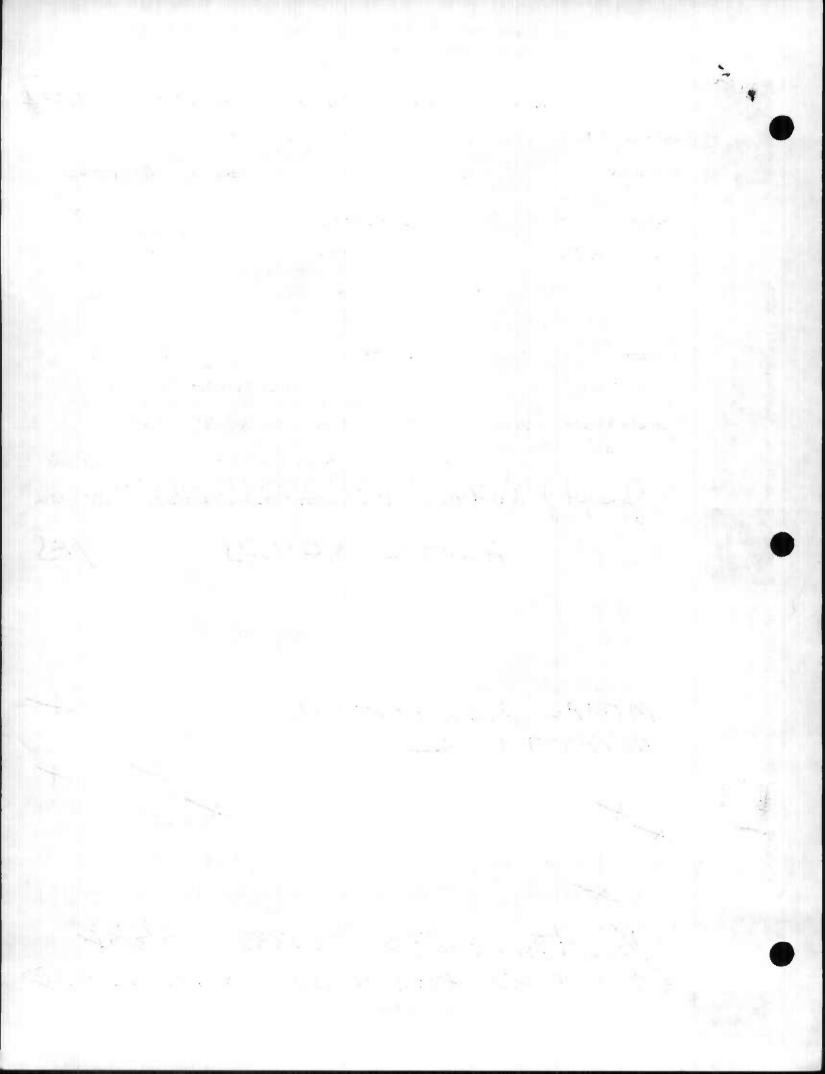
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x 68760,	ate be hysicia the bur	/Medical Examiner	Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Diseese or Injury that initiated evants resulting in deeth) Lest	b		as a conse							1	
rds, P.O. Box	at the did by the atached	d by Physician/M	Pert II. Other significant condition MTRA	ona contributing to di	eath but not resu	ulting In the C	anderlying c	ausa giv	ren in Part t	t.		'es 2□ No	3 🗆 Pro	to the cause of death? obebly sub-unknown Vara autopsy findings valiable prior to
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0	ding Ph. Aftar th funara		27. Mannar of Deeth 1 Naturat 5 ☐ Pandir	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	of 2	8c. Injur Wor			28d. Dascribe h	ow Injury occur	red	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Certification:	2 Accident Investi 3 Suicide 6 Could 4 Homicide datam	not be 28a. Place	of Injury - At ho	me, farm, si	M treet, factory		Yas 2□	5.5	28f. Location (S City or Tow	Straet and Numb n, State)	ber or Ru	ral Route Number,
	the Hospital iin 24 hours the Funeral I		(Check only 2 Madical one)		best of my know asis of examinat ner statad.	wledga, daai ion and/or ir	rvestigation	, In my c	pinion, dea	nd place, ath occurr	ed at the time, o	date and placa,	and due	to the cause(s)
	To the comple	X	29b. Signature and title of certifie	Tuna	e W	111	290	Licens	203	33	3	29d. Date styne	190	(Lody, Folia)
	3		K. ZONIE	who completed cause	183	8- a	Print) REE	NA	EE-	R	DI	IKES	VICE	EMP
	Stat		31. Data filed (Month, Day, Year)	July	legistrar's Signal	-Randa	82.				,			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth **Physician** July Bay 1998 William DeRvee Westervelt Jr. 5:00 pm. /Medical 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2205 Green Haven Way Hampstead Carroll Hours Min. 8. Date of Birth 9. Birthplaca (State or Foreign Country)
Aug. 31,1933Massachusetts 6. Sex _____ 1 △ A 2 □ F 5. Social Sacurity Number 7. Age (In yrs. last birthday) if Under 1 Year **Funeral** Months Deys 055-28-7652 64 Yrs Director Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 show Injury or other traumatic event, the Med cal Examiner must be notified at Maryland Carroll 1 Yes 2 No Hampstead Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2205 Green Haven Way U.S.A. 21074 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-it Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - Americen Indian, permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic axent Bleck, White, etc. 1 Never Marriad 2 Married 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Ward Machinery 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William D. Westervelt Avis E. Connerv 2 19e. Intormant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Westervelt - wife 2205 Green Haven Way, Hampstead, Md. 21074 20a. Method of Disposition 20b. Plece of Disposition (Name of Dete 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Mt. Zion Cem. July 13,1998 Freeland. Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Eckhardt Funeral Chapel Salt 3296 Charmil Dr. Manchester, Md. 21102 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximate interval Betw Onsat and Daath **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as e consequence of): Examiner physician and the burief-transit Sequentially ilst conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseasa or Injury that initiated avents resulting in death) Last Dua to (or es a consequance of): The law requires that the death certificate be an Physician/Medical the Due to (or as e consequence of): ettending use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Nos 2 No 3 ☐ Probably 4 ☐ Unknown þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death? peen ate hes certificate 1 Yes 2 1 No 1 ☐ Yes 2 € No To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was cese raterred to medicel 26. Place of Death (Check only one) examinar? Other: 4 Nursing Home 5 N Pesidence Medical Certification: To 1 🗆 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 8 Other (Specify) 27. Menner of Death 28a. Data ot Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 29a. Certifier 16/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madleer Examination on the basis of examination and/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s)

29c. License number

of death (Item 23a) (Type, Print)

Julia Davidson Mandall

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2. Registrar's Signatura

4800

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Rock Rd

29d. Date signed (Month, Day, Year)

State

Registrar

30. Na

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

d-address of p

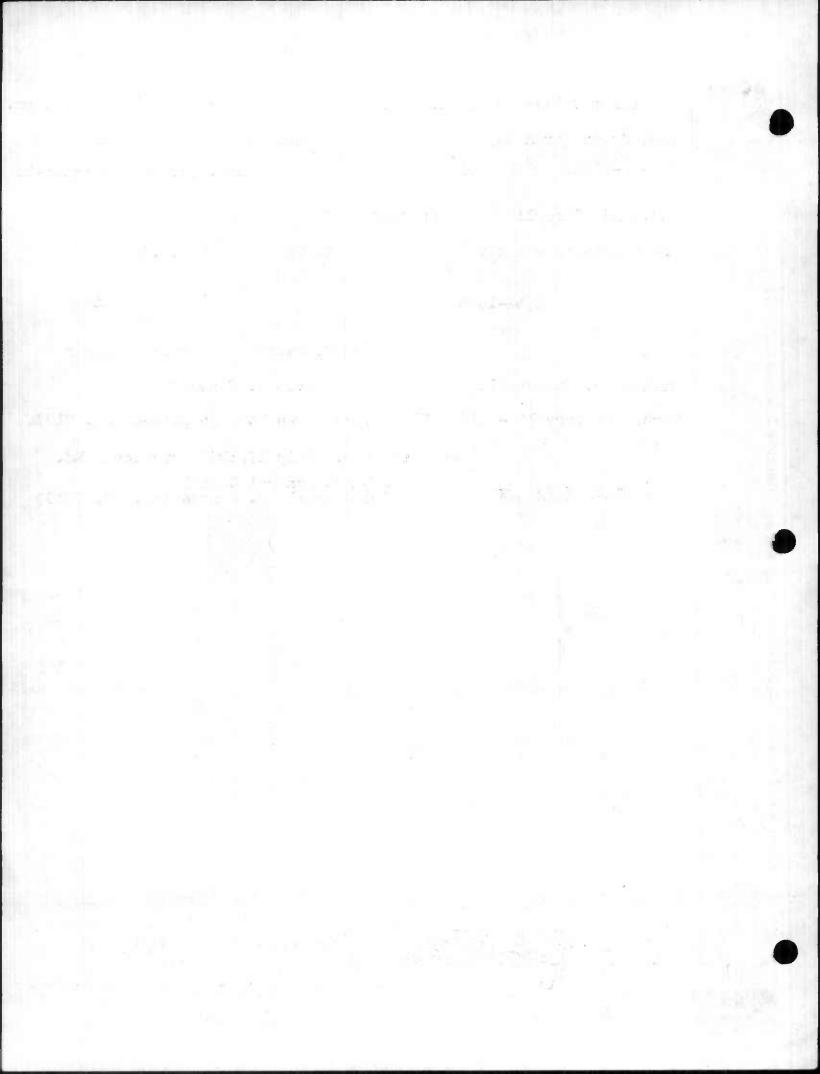
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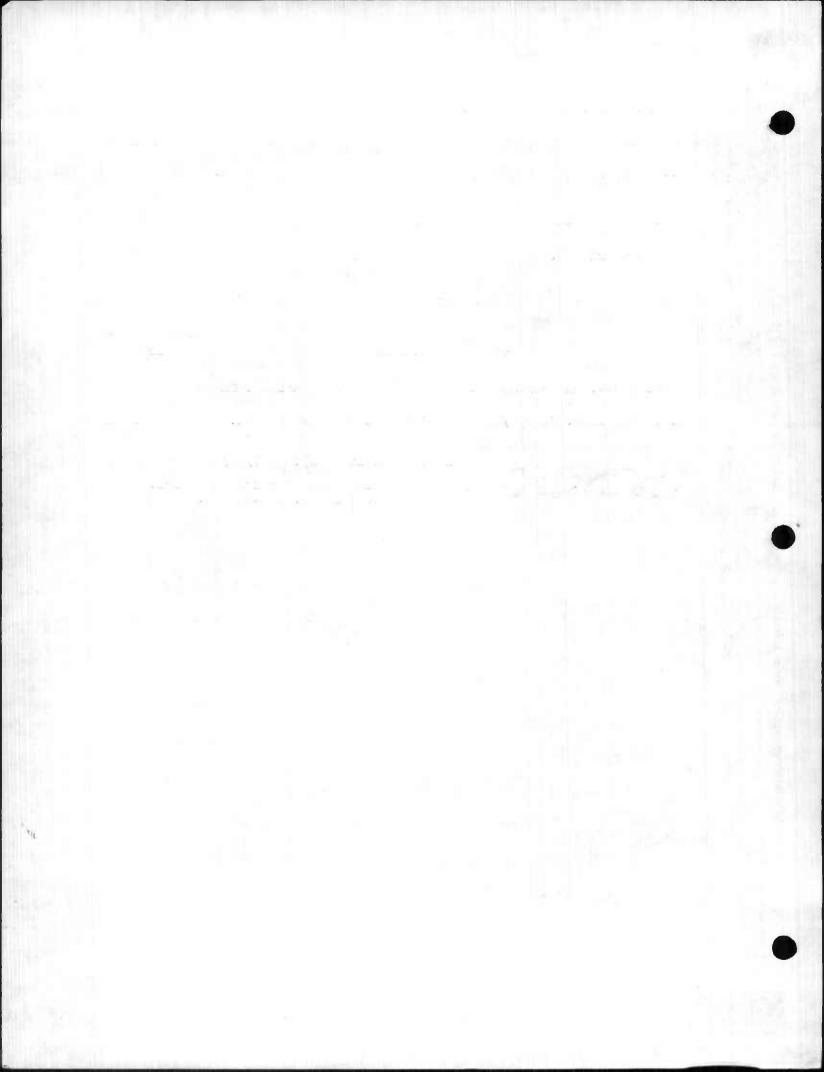
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Division of Vital



State of Maryland / Department of Health and Mental Hygiene

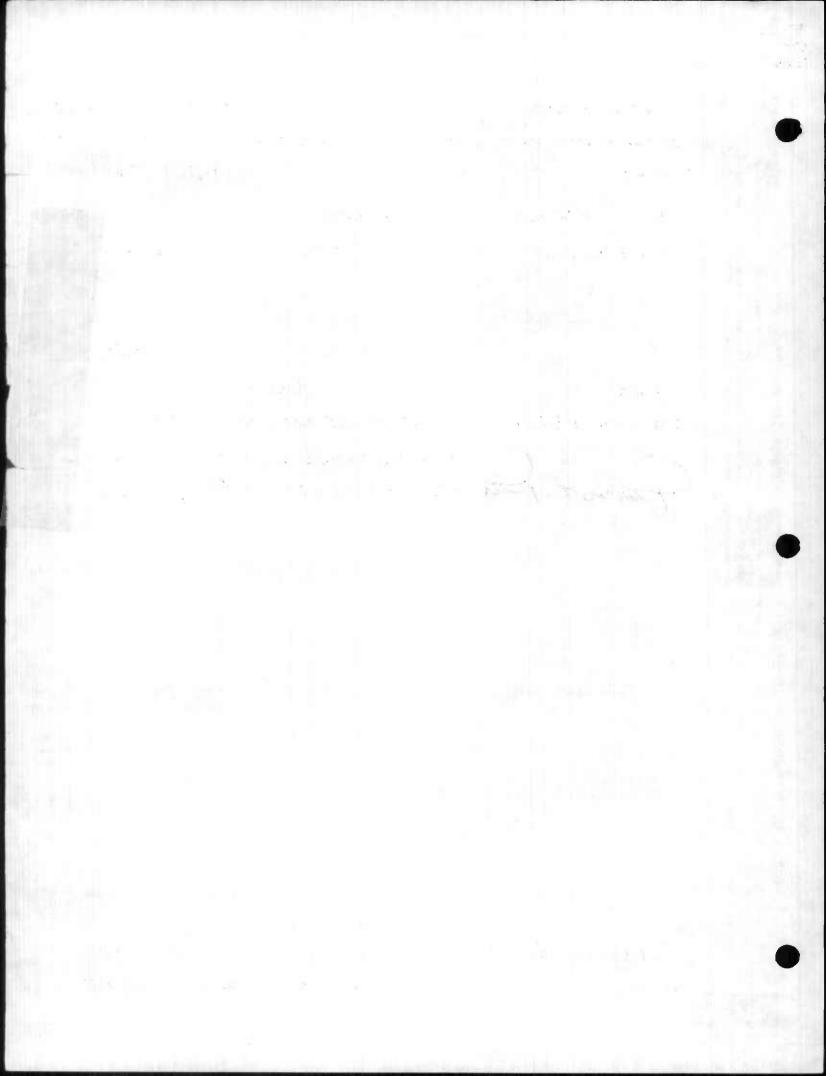
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/Medical	SPENCER G.H. ZIM				July	9, 199	
Examiner	4a Facility Name (If not institution, gi	re street and number)		4b. City, To	wn, or Location of Dec	th 4c. County	of Death
	Edenwald		7 444 4	Tows			imore
Funeral Director	577-60-1955	Sex 7. Age (In yrs. last 97	Yrs. Months	r 1 Year If Under Days Hours	Min. (Month, I	irth Day, Year) 4, 1900	Birthplace (State or Foreign Country) Md .
with the Maryland a or 28a-f show be notified at	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City,	Town or Location				10d. Inside City Limits
after death with the Marylar or items 23e or 28e-f show things must be notified at Funeral Director	Md. Baltir	ore To	wson				1 ☐ Yes 2 ☒ No
or 2	10e. Street and Number		10f. Zip	Code		10g. Citizen of V	Vhat Country?
death v	800 Southerly Rd.	_		1286		USA	
fler death v	11. Marital Status 1 Never Merried 2 Married	12. Was Decedent Ever in U,S. Armed Forces?	13. Wes Dece	dent of Hispanic On cify Cuban, Mexical	gin? (Specify Yes or h , Puerto Rican, etc.)	lo- 14. Hac	e - American Indien, k, White, etc.
0 5 1		1X Yes 2 □ No If Yes, Give Year or Dates: WW-I	1 ☐ Yes	2☑ No Specify:		Specify	White
n 72 hours	15. Decedent's E	ducation	16a. Decedent's Usu	al Occupation		16b. Kind of Bu	usiness/Industry
2	(Specify only highest gr	College (1-4or 5+)	life. DO NOT u	ork done during mos se retired)	or working	Internal	l Revenue
d 212 filed with Hygiena. ther than	12		Attorney			Service	
Maryland de flie th and Mental Hy 7 is marked oth traumatic avent To Be (17. Father's Neme (First, Middle, Las.)		18. Moth	or's Name (First, Midd	le, Maiden Sumem	e)
should to marked umarics					ie M. Rigg		
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Baltimore, Maryland 212-1 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: if item 27 is marked other than eny injury or other traumatic avent, the Monce. To Be Compl	21. Signature or Funeral Service Life	ANA			uneral Hom	e, Inc.	
	22a Part 1 Enter the dispass or one	inlications that caused the death			Towson, Md		Approximate .
Rhysisian	23a. Pert1. Enter the disease, or con shock, or heart feiture. List only			Je ot dyling, soch as	cardiac or respiratory	arrest,	Intervat Between Onset and Death
Physician /Medical	Immediate Cause (Finet		troke				1,24
Examiner	disease or condition resulting in death)	a	is a consequence of)				
je je		. Inds	fre 1 1/1	1/ molares	n's Kus	0 00000	t 240
executed is lugared	Sequentially list conditions,	b. Due to (or a	is a consequence of):	1	17	yeun	
O _/ 10 =	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a ny	hone 50	levtie	diseas	1	104n
68760, ifficeta be a g physiofian, es tha buria	thet initiated events resulting in death) Last	Due to (or a	s a consequence of):				
- 5 De =		d					
Box sath cert for use							
P.O. Box at the death cert d by the stendin etached for use	Part II. Other significant conditions	ontributing to death but not resulti	ing in the underlying o	ause given in Part I			ntribute to the cause of death?
						Yes 20 No	3 Probably 4 Unknown
Records, P.O. Box ha law requires that the death cer has been signed by the strendinge 2 should be detached for usa ompleted by Physiclan/k					24a. Wa	s an autopsy	24b. Were autopsy findings
The law require that has been sipage 2 should Completed					pe	formed?	available prior to completion of cause of death?
G 4 4 9 E					10	Yes 2 No	1 Yes 2 No
Vital Receipton: The law conflicate has irrector, page 2	25. Was case referred to medicat			26. Place	of Death (Check only	/ '	
F 5 5 5	axaminer?	Hospitat: 1 Inpatient 2 E	R/Outpatient 3 D	100	rsing Home 5 Re		er (Specify)
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Vision Attending or death. ector: After funs by the funs iffication	2 Accident investigation	n	М	1 Yes 2	No		
Division of attending P is after death. In Director: After ted in by the funaric Certification:	3 Suicide 6 Could not to determined	 28e. Place of Injury - At hom building, etc. (Specify) 	e, farm, street, fector	y, office		(Street and Numb own, Stele)	er or Rural Route Number,
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	30. Mame and address of person who	completed cause of death (Item 2	Re) (Type Print)	1/ 1	161	//	1-10
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State	31. Date filed (Month, Day, Year)	32. Registrar's Signatur			1		
Registrar	JUL 1 3 1998	Julia Davidso	n-Pandall				0.00
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ı	Physicia /Medica		1. Decedent's Name (First, Middle Homer Leroy E		5						2. Dete of Dea Month JUNE 2	Dey 13, 1998	Yeer }	3. Tima of Death 0040AM	
	Examine		4a Facility Nama (If not Institution	, giva stre	et end numb	er)				4b. City, Town, or	Location of Death	4c. Count	y of Death		
			WASHINGTON COUN	TY HO	OSPITA	L C.C	.U.			HAGERSTO				COUNTY	
ı	Funeral Director		5. Social Security Number 191-46-4033	6. Sex		Age (In yrs.	lest birthdey Yrs.	Months	er 1 Year Days		8. Dete of Birt (Month, De May 18,	1929	9. Birthple Count Tenne	eca (Stete or Foraign ry) SSCC	
	Inyland show		Usuel Residence of Decedant 10a. Stete 10b. County	· · · · · ·		10c. Ci	ty, Town or L		h / # a.			10d. Insid			
	within 72 hours after death with the Maryland within 72 hours after death with the Maryland then. Then "natural", or items 23s or 28s-f show the Modell Emminer must be notified at ministered by Funeral Director.		Md. Wash	ingt	on			Hage 101. z	ip Code	on		10g. Citizen of	What Count	1 XYes 2 □ No	
			38 East Frankl			at Evenia I	10	W. D.		1740			.S.A.		
020	urs after dea al', or items Example m	2	11. Maritel Status 1 □ Navar Married 2 ☒ Marr 3 □ Widowed 4 □ Divorced	ed	Wes Decede Armed Force 1 ☐ Yes 2 If Yes, Give Yaar or Date	es? □XNo	13.	If Yes, sp		Hispanic Origin? (S pan, Mexicen, Puart Specify:	o Ricen, etc.)		ock, White, e	etc.	
21215-0020	gas 1 and 2 should be filed within 72 hours aft it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or or other traumatic avent, its Mours Earth or or other traumatic avent, its Mours Earth	Completed	15. Decedent (Specify only highest Elementery/Secondary (0-12)	t grade co	on <i>mpleted)</i> College (1-4	III DO NOT USA I				rking	16b. Kind of E				
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Maryland	ould be filed with Mental Hygiene. arked other than artic avent, the	one	17. Fether's Neme (First, Middle, Unknown	.ast)						18. Mother's Ner	ne (First, Middle, 1v	Maiden Sume.	me)		
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	alth a alth a 27 is		Rose L. Brooks	(Wif	e)		P.O.	Box	250	3 Hagerst	town, Md.	21741			
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Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral f	Certific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		8e. Plece of building	Injury - At h , etc. (Speci	ome, term, s	treet, facto	ory, office		28t. Location (: City or To	Street end Num vn, Stete)	ber or Rure	l Route Number,	
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			Strohen S.	Ra	eted ceuse i				nn S	treet, Ba	ltimore.	Maryl	and 21	1201	
	State Registra	e	31. Date filed (Month, Day, Yeer)	1998		s'Sign					•				



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Mildred 1998 L. Bowers 5:00 AM June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🕅 F 84 Months Days Hours 213-64-5964 1913 Director Waynesboro, PA Usual Residence of Deceden the Marylend 10c. City. Town or Location 10d. Inside City Limits 10a State 10h. County 7 is marked other than "naturel", or items 23s or 28s-f show traumstic svent, the Medical Examinar must be notified at PA Franklin 1 ☐ Yes 2 No Director Greencastle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nit. Pages 1 and 2 should be filed within 72 hours efter deeth with sartment of Health and Mentel Hyglene.
ortant: If item 27 is marked other than "naturel; or items 23a or injury or other traumatic event, the Medical Examiner manifer. 11591 Williamsport Pike 17225 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Stetus 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: Specify: White by 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Own Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob David Funk Lilly Mae Cool 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy B. Roschli 11591 Williamsport Pike Greencastle PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other piece) 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 X Removal from State Department of Important: If St Andrew's Cemetery 6/25 Waynesboro PA 17268 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Miller-Grove Funeral Home 21. Signature of Funeral Service License 521 S Washington ST Greencastle 17225 John C. Lynch 23a. Part1. Enter the disease, or combilications that ceused le death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lit. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner horascula dias Examiner physician and the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): use es signed by the a d be deteched f 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 Probably 4 Unknown 1 ☐ Yee 2 ☑ No by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 2000 certificate 25. Was case referred to me examiner? or Attending Physician: funeral director, Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No of inpatient 2 □ ER/Outpatient 3 □ DOA After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1- Natural 5 Pending 2 No 24 hours efter deeth. investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homlcide Hospital 1 Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 8 29d. Date signed (Month, Day, Year) 29b. Signature, 29c. License number

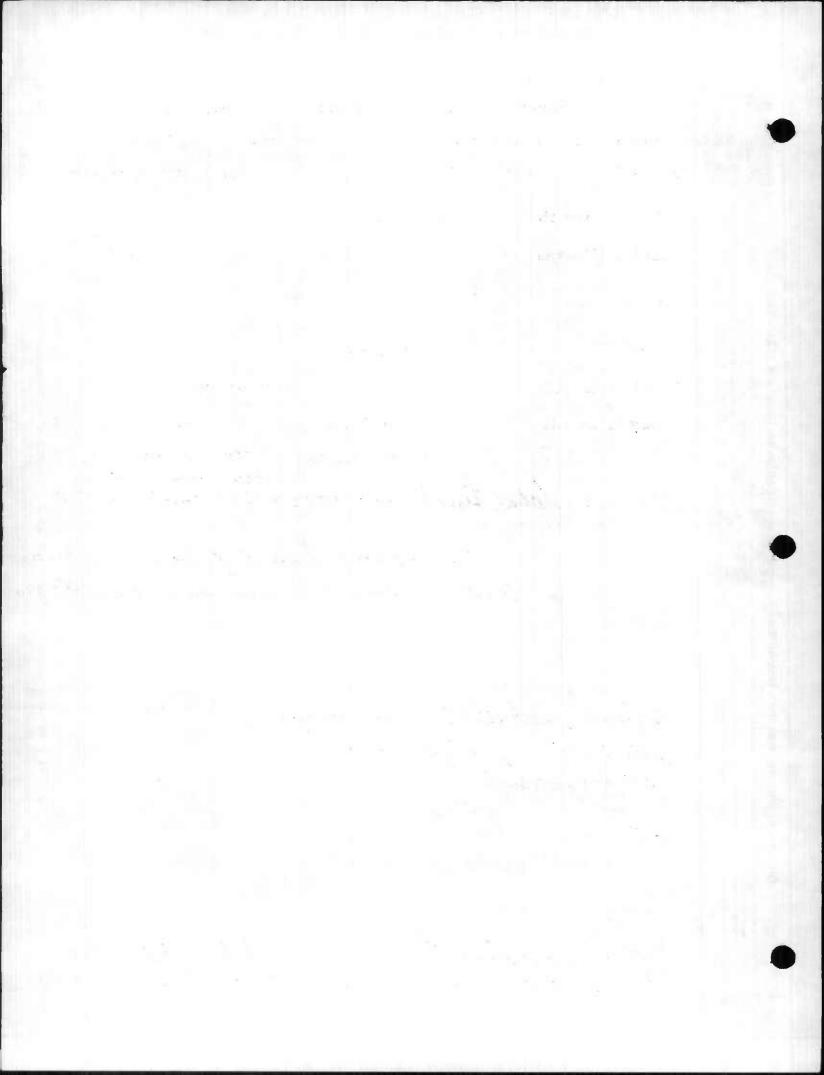
23a) (Type, Print)

32. Registrar's Signature

Fulia Davidson

JUN 2 3 1998

State Registrar

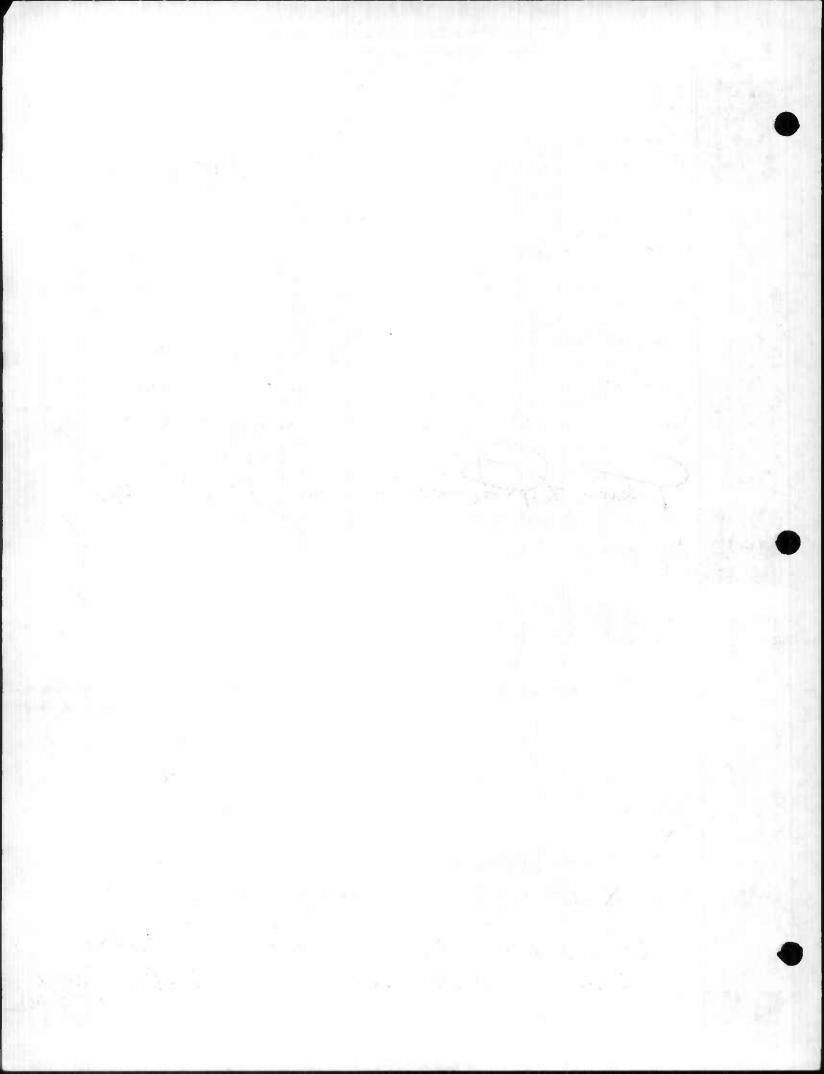


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Benny Albert Boyer 1998 8:10 P.M. June /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3229 Ward Kline Rd. Muersville Frederick Hours Min. April 29 17 28 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 9. Birthpiece (State or Foreign Funeral Months Deys 1 ☑ M 2 □ F Maryland 216-36-2642 60 Yrs Director Usuel Residenca of Decadent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examiner must be notified at Director Frederick Myersville 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3229 Ward Kline Rd. 21773 U.S.A. permit. Peges 1 and 2 should be filed within 72 hours efter death a Department of Health and Mental Pygiene. Important: if item 27 is marked other than "hatural", or items 28a any Injury or other treumstic event. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

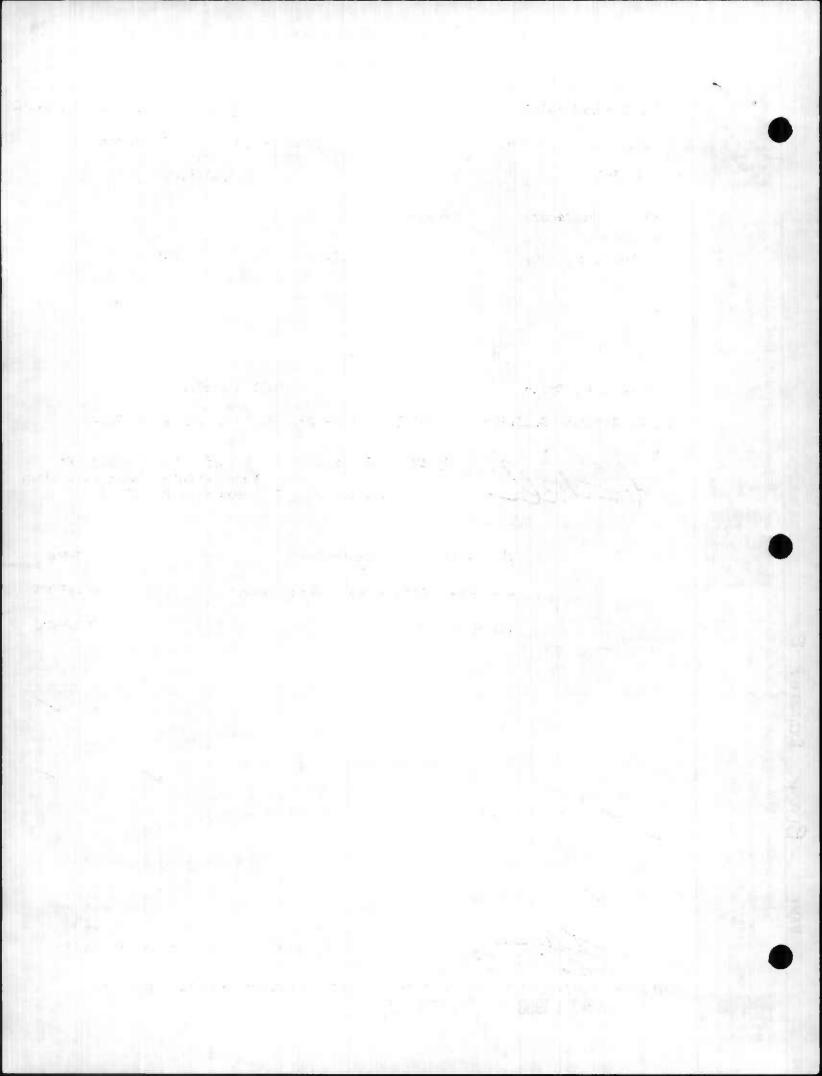
1 △ Yes 2 □ No If Yes, Give Yeer or Detes: 57 ~ 60 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Lineman Telephone Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Edwin Austin Boyer Myrtle Rebecca Eccard 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3229 Ward Kline Rd. Myersville, Md. 21773 Evelyn R. Boyer (Wife) 20e. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Repoyal from State
Donetion 5 Other (Specify) Smithsburg Crematory June 10,1998 Smithsburg, Md. reral Service Licen 1. Signature of 22. Neme end Address of Fecility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. **Physician** /Medicai Immediate Ceuse (Final disease or condition resulting in deeth) PANCREATIC CANCER 2/98 Examiner Due to (or es e consequença of) Examiner The law requires that the death certificate be executed the buriel-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, ettending physician Physician/Medical Due to (or es e consequence of): signed by the etter Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by Completed 24e. Wes en eutopsy 24b. Were eutopsy findings peeu eveilable prior to completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 5 Residenca 8 Other (Specify) 2 ER/Outpetient 3 DOA After this 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of Injury 28e. Dete of Injury (Month, Dev Year) 28c. Injury et Work? 1 Neturel
2 Accident 5 Pending Investigetion death. 1 TYes 2 □ No within 24 hours efter deat To the Funeral Director: in by the 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide edical Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as steted.

Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner steted. 29a Certifier 29b. Signature apd title 29d. Dete signed (Month, Dey, Year) dress of person who completed cause of deeth (Item 23e) (Type, Print) 31. Dete filed (Month, 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth Month Dev **Physician** 10:15 AM DOROTHY SMITH BLACK 1998 JUNE /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner Baltimore ST. AGNES BALTIMORE HOSPITAL 5. Social Security Number ff Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 10 M 20 F Months Days Hours Yrs. 98 4/25/1900 PA Director 201-05-9982 Usual Residence of Decedent with the Manyland 10a State 10b. County 10c, City, Town or Location 10d. inside City Limits MD Baltimore Catonsville 1 XYes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filled within 72 hours efter death with Department of Heelth and Mantal Hygiena. Important: If Hem 27 is marked other then "any Injury or other traumer." r than "natural", or items 23s or the Medical Examiner must be 1 USA 21228 16 Fusting Avenue Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. Bleck, White, etc. 1 Never Married 2 Married 1 Yes MNo If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify: Specify: White P 3 ☑ Widowed 4 □ Divorcad Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 0 Housewife 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Hallie Englehart Percy John Smith 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3113 The Oaks Rd., Ellicott City, MD Mary C. Scranton Griffith 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location · City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Spring Hill Cemetery 6/12/98 Shippensburg, PA of Funeral Service Licens 22. Name end Address of Fecility Fogelsanger-Bricker F.H., Inc. once ch P.O. Box 336, Shippensburg, PA 17257 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediete Cause (Finel diseese or condition resulting in deeth) Medma ASPIRATION PNEUMONIA WEEK Examiner Due to (or es e consequenca of): Physician/Medical Examiner CEREBROVASCULAR MONTHS ACCIDENT physician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): YEARS DEMENTIA Due to (or es a consequenca of): as 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yas 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an eutopsy parformed? Completed page 2 1□ Yes 2 No 1 Yes 2 No Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA After this 28e. Dete of Injury (Month, Dey Year) uneral 28d Describe how injury occurred 27. Menner of Death 28b. Time of 28c. injury at Work? Certification: 1 Naturel 5 Pending investigation 1 TYes 2 □ No 2 Accident aftar deatl Director: 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide 24 hours 1 Scritifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as stated. 29e. Certifier Medical completaly 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) within 2 29b. Signature end title of certiful 29c. License number 29d. Dete signed (Month, Dey, Year) JUNE 8, 1998 s mo 30. Neme end eddre in other or completed cause of deeth (Item 23e) (Type, Print) AVENUE, BALTIMORE, MD 900 CATON GHANI, M.D. MAZEN 32. Register's Signature State Registrar

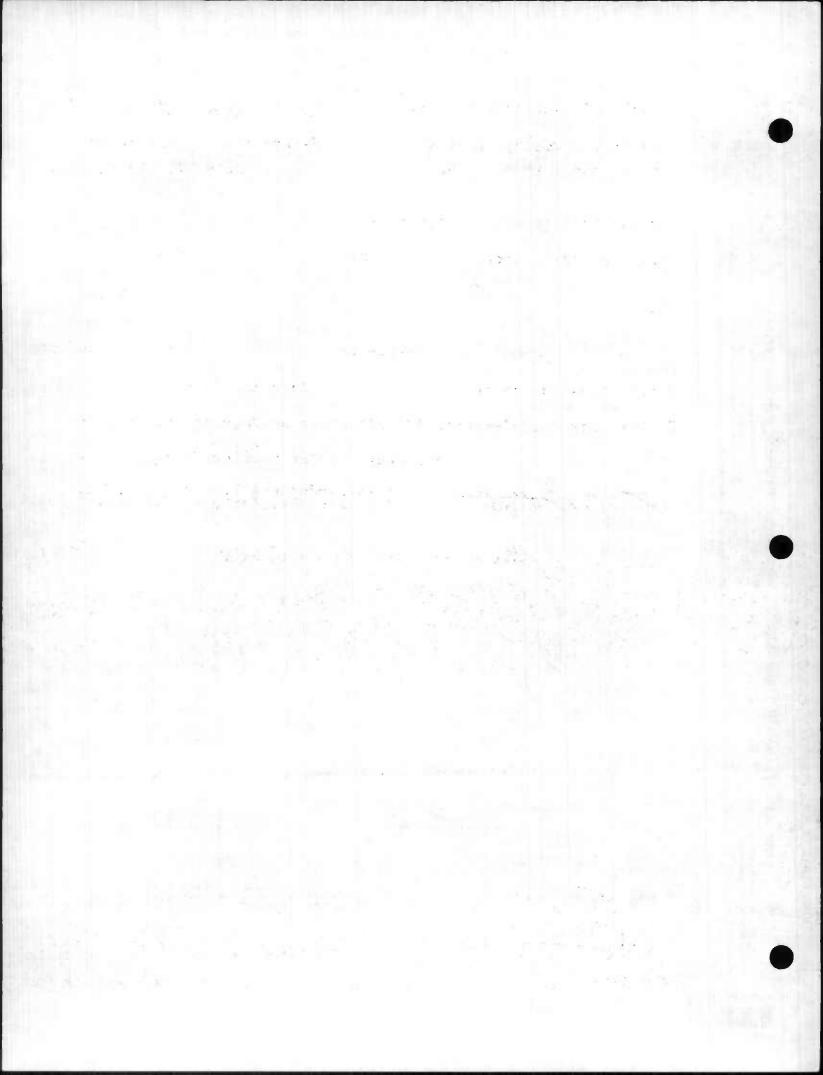


State of Maryland / Department of Health and Mental Hygiene

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/Medical		John Frede	rick Ba	rnhar	t				JUNE		998	1447
Examiner	4	Facility Neme (If not institution, give	re street and number)				4b. City, To	wn, or Lo	cation of Dea	h 4c. County	of Death	
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uneral		Social Security Number 6. 5	Sex 7. Age 1 ☑ M 2 ☐ F	(In yrs. last	birthday)	If Under 1 Ye Months Day		Min.	8. Date of Bi	th Year) 192	9. Birthp	plece (State or Fore itry) ryland
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important: any injury phos.	2	Signafure of Funeral Service Lice	nsee			Name and Ad			Funer	al Hom	e. Tr	nc.
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	2	3a. Pai 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. [Do not enter	r the mode of	tying, such as	cardiac o	or respiratory	errest,		Approximate Interval Between
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Barrhart, John



State of Maryland / Department of Health and Mental Hygiene

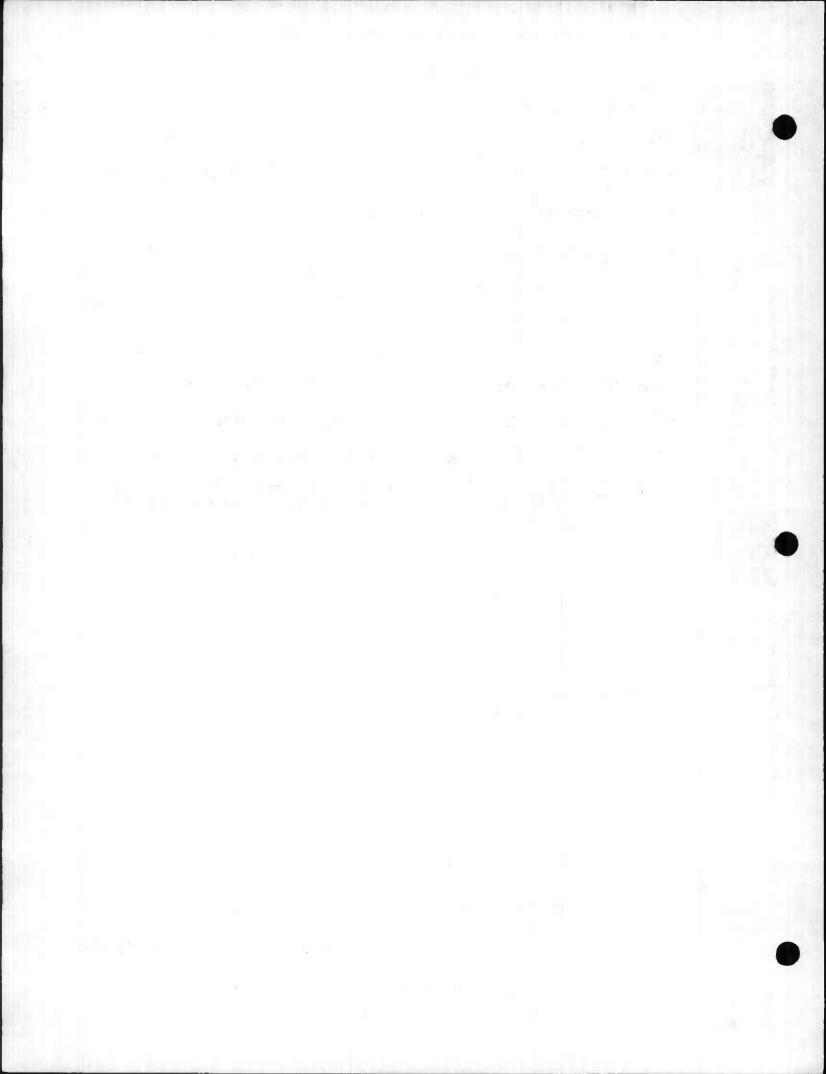
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 20, 7998 Harlene Ariel Braden 6 p.m. /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Grantsville Goodwill Mennonite Home Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Days 1 M 2 F 226-44-9127 92 Yrs. Director May 28, 1906 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if from 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be nonlined. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Garrett Grantsville 1 ☐ Yes 217 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21536 891 Dorsev Hotel Road USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 8 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Samuel Wilson Bittinger Mary Catherine Hetrick 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Bruce B. Braden, Sr./son 5410 Antoinette St., Sarasota, FL 20a. Method of Disposition 20b. Piace of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 □ Removal from State Maple Grove Cem. June 25, 1998 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Newman Funeral Homes, P.A., P.O. Box 275 eumau 179 Miller St., Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teriure. List only one cause on each line. **Approximate** Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) e. CONGESTIVE HEART

Due to (or as e consequence of): 1 Hours Examiner Examiner law requires that the death certificate be executed physician and the buriel-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) esn signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PEPTIC ULLER DISEASE p 24b. Were autopsy findings available prior to completion of cause of death? ANGMIA 24a. Was an autopsy performed? ata has b certificata 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No P this funeral 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of injury 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 1 Naturei 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No To the Hospitat or Atter within 24 hours after dea To the Funeral Director complataly filled in by th 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D-25638 June 21, 1998 S. Chang, M.D., 10701 New Georges Creek Rd., S.W., Frostburg, MD 21532 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State

DHMH 16 Rev 6/95

Registrar

JUN 26 1998

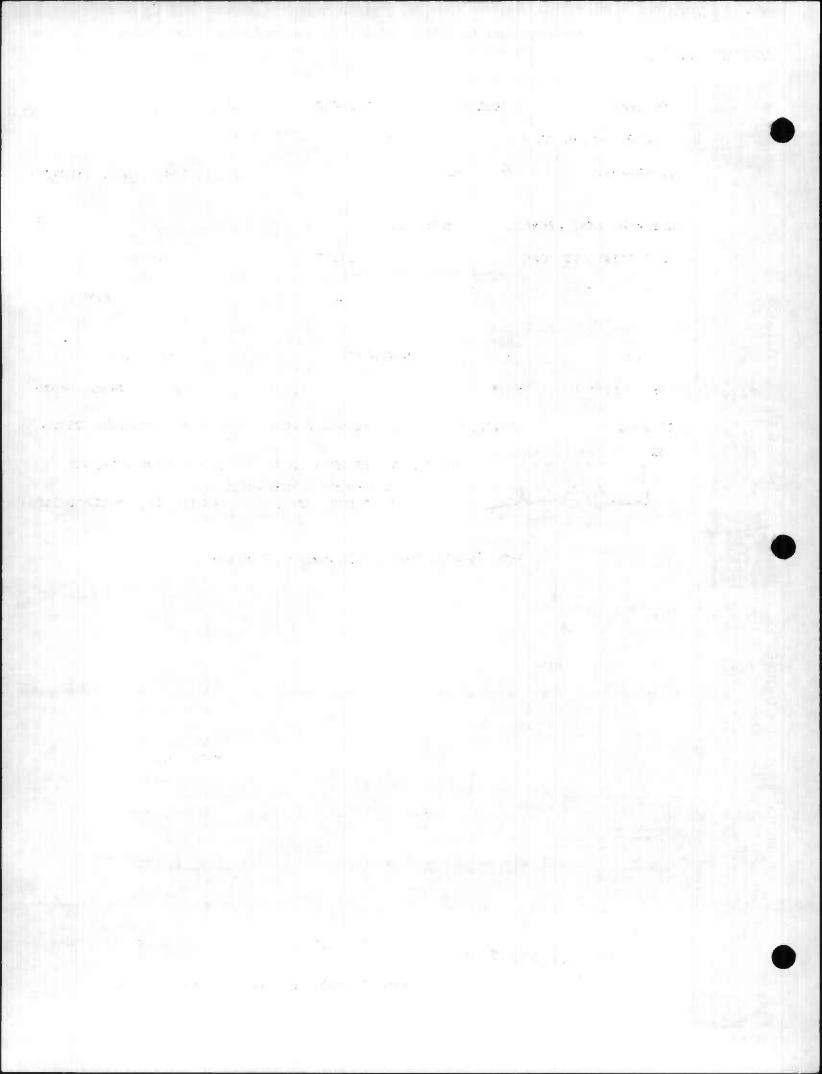


DOROTHY BURGESS

State of Maryland / Department of Health and Mental Hygiene

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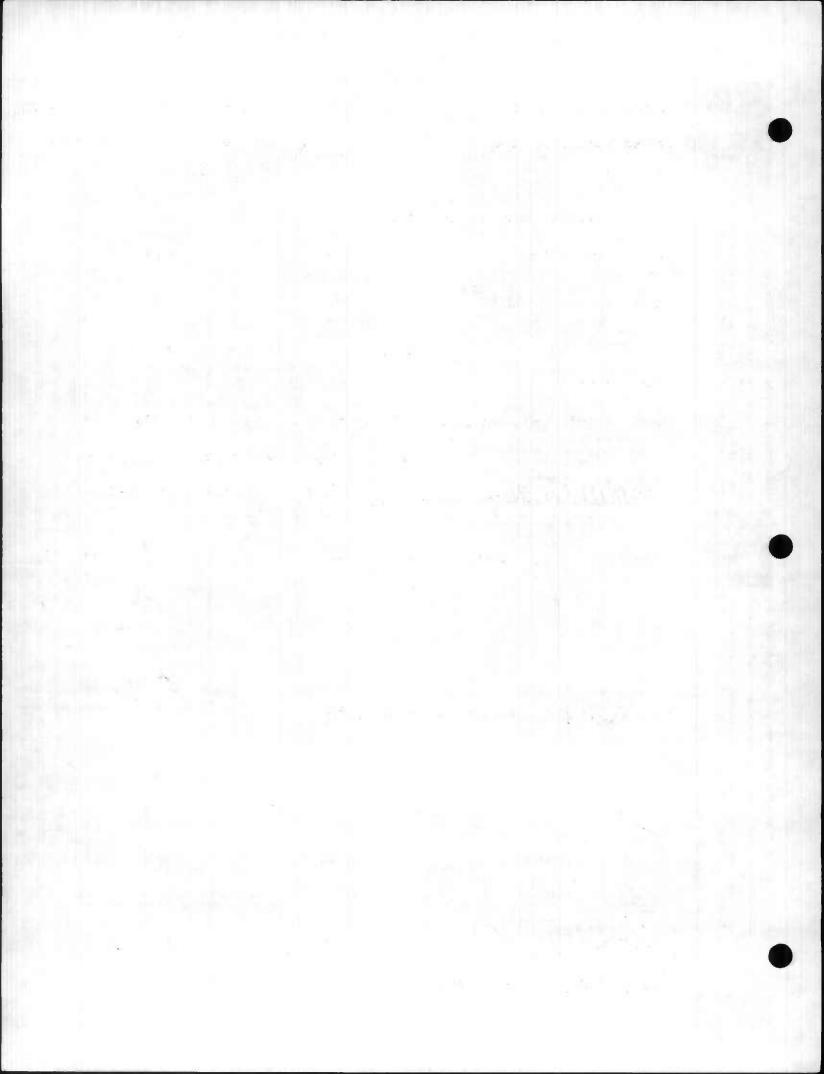
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Tima of Death 2. Data of Death 1 Decedent's Name (First Middle Last) Month **Physician** 1:00PM June 1998 Katherine P. Brown /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Prince George's Sacred Heart Home, Inc. Hyattsville If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 05/30/1913 If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months Days Yrs. 212 01 7999 85 Maryland Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show r than "natural", or items 23s or 25s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Prince Georges Seabrook Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9708 Tuckerman Street 20706 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Bace - American Indian Black, Whita, atc. 1 ☐ Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 H 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) h and Mental i John P. McLeish Jessie Sime 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If them 27 is n 9708 Tuckerman St/Seabrook MD 20706 Aulden Sutphin (personal rep.) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stala 4 ☐ Donation 5 ☐ Other (Specify) à 6/12/98 Metropolitan Crematory Alexandria VA 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Fecility Advent Funeral & Cremation Services Vagori 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsal and Daalh **Physician** /Medical Immediete Ceuse (Final disease or condition rasulting In death) month Carcinoma Examiner Due to (or as a consequence of): Examine bunal-transit The law requires that the death certificata be executed Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) and physician a the bunal-Box 68760, Physician/Medical Due to (or as a consequence of): 950 23b. Did tobacco uss contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 0 the detached 1 Yss 2 No 3 Probably 4 Unknown signed by Syndrome and cerite dementia Records, P. þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? peen complation of cause of death? has certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) 28 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes After this funerel 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: or Attending 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: A complataly filled in by the fi 1 ☐ Yes 2 ☐ No deeth. investigation 2 Accident 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, and due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura 29c. License number who completed cause of deeth (Item 23e) (Type, Print) 7500 breenway Un Dr. Greenbeltvud 20770 32. Registrar's Signature who Davidson 15 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

21367

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Deeth 3. Tima of Death **Physician** Month Yaar June 8,1998 Martha Skrok Babbitt 02:25pm /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Nema (If not institution, giva street and number) 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 8. Data of Birth April 7, 1922 Pennsylvania If Undar 1 Yeer If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthpiece (State or Foraign Country) **Funeral** Months 1□ M 2□ F 76 292-14-1828 Yrs. Director Usuel Rasidance of Decedant r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√Nas 2 No Directo Maryland Anne Arundel Shadvside 10e. Street end Number 10f. Zin Code 10g. Citizen of What Country? must be n USA 5190 Chesapeake Ave. 20764 nit. Pages 1 and 2 should be filed within 72 hours after death arithent of Health and Mental Hygiene. ortant: If Nem 27 is marked other than "natural", or learne 23 injury or other traumatic event, the Medical Examiner must Funerai 12. Was Dacedant Evar in U,S Armed Forces? 13. Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 Yas 2 No If Yas, Giva X Yaar or Datas: 1 Navar Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2☐No þ Specify: White 3℃ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Dacadant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Eiamantary/Secondery (0-12) Collega (1-4or 5+) 12 Homemaker At_home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be 0 Skrok Unknown Unknown 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) James F. Babbitt/Son same as item 10 20e. Mathod of Disposition

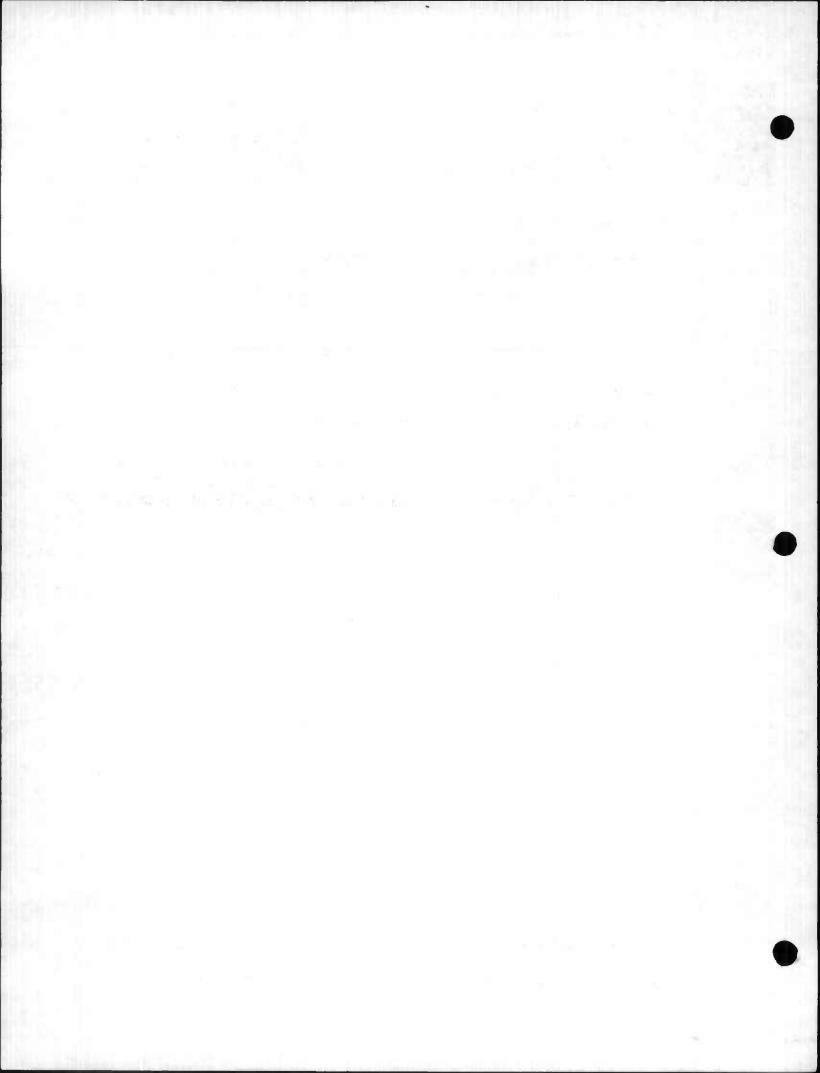
1 Buriai 2 Cremetion 3 Ramoval from State 20b. Place of Disposition (Name of cematary, cramatory or othar place) 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Othar (Spacify) 6/11/98 Alexandria, VA Metropolitan Crematory George P. Kalas Funeral Home, P.A. ales 2973 Solomons Island Rd., Edgewater, MD 21037 Part . Entai he disease, or complications thet caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata intarval Batween Onset end Death **Physician** Immediata Cause (Final disaesa or condition resulting in death) /Medical Seps1s 6 weeks Examiner Dua to (or as a consequence of) Physician/Medicai Examiner 6 weeks The law requires that the death certificate be executed nding physician and use as the burial-transit Sequantially list conditions, if eny, laading to immadiata ceusa. Entar Underlying Causa (Disaasa or injury that initieted events rasulting in daath) Last Dua to (or as a consequence of) 6 weeks P.O. Box 68760. Preumoma. Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Pert i. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evailable prior to complation of causa of death? 24a. Was an autopsy performed? Completed page 2 1⊠Yes 2□No 1 XYas 2 No or Attending Physician: Be 25. Was casa raferred to medical axaminar? 28. Piece of Deeth (Check only one) Hospitai: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yas 2 ☑ No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) iuneral 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred After 5 Panding invastigation 1 Neturai e Hospran, n 24 hours efter death.
he Funeral Director: Aft 1 Yes 2 No 2 Accident 6 Could not ba 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida 1 Cartifying Physician: To tha best of my knowledge, deeth occurred et tha time, date end place, end due to the ceuse(s) and menner es steted.

2 Medicat Examiner: On tha basis of exemination and/or invastigetion, in my opinion, daath occurred at tha time, dete end placa, and due to tha causa(s) and mannar stated. 29e. Cartifian completely (Check only one) within 2 29d. Data signed (Month, Day, Year) 29b. Signeture and titla of certifiar 29c. Licansa number D37891 June 11,1998 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 9801 Georgia Ave Silver Spring MD.20910 Amit Rajvanshi MD 31. Data filad (Month, Day, Year) 32. Registrar's Signatura State

Julia Davidson-Randose

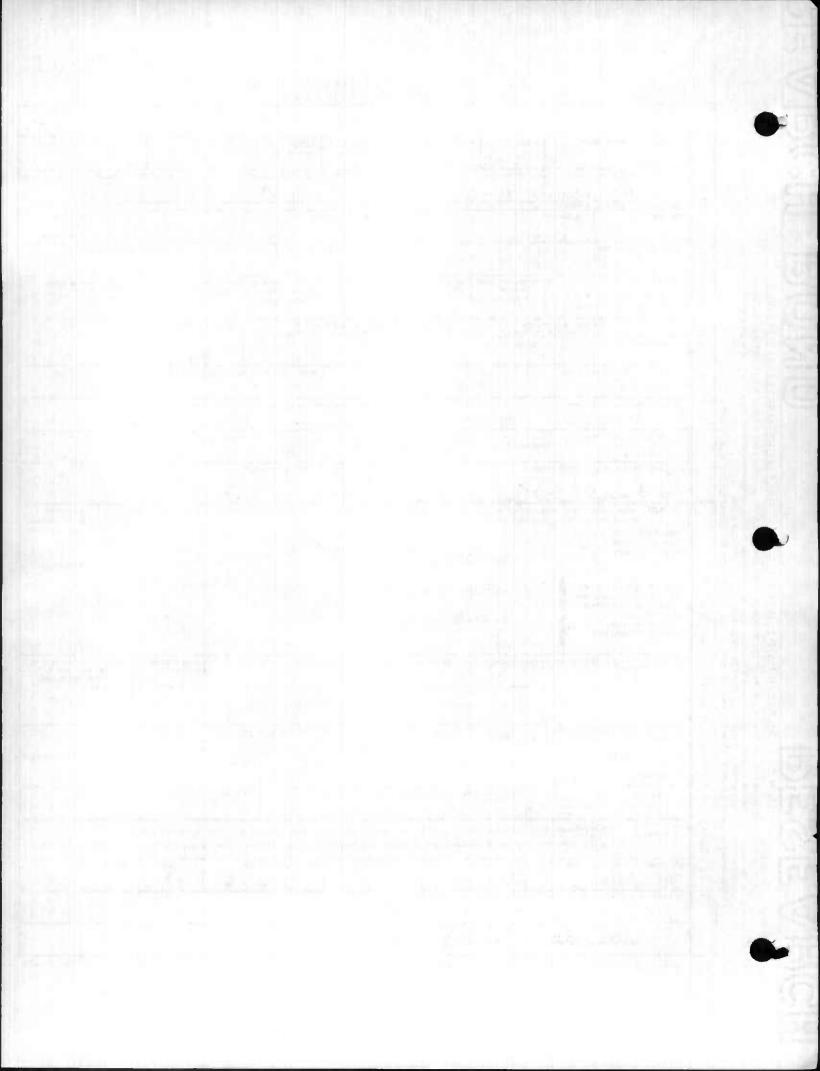
DHMH 16 Rev 6/95

Registrar



BALTIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physic	d in by the funeral director, page 5 should be detached for use as the buria
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Surs after death. Page 6 may be retained by the hospital or attending physic	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial

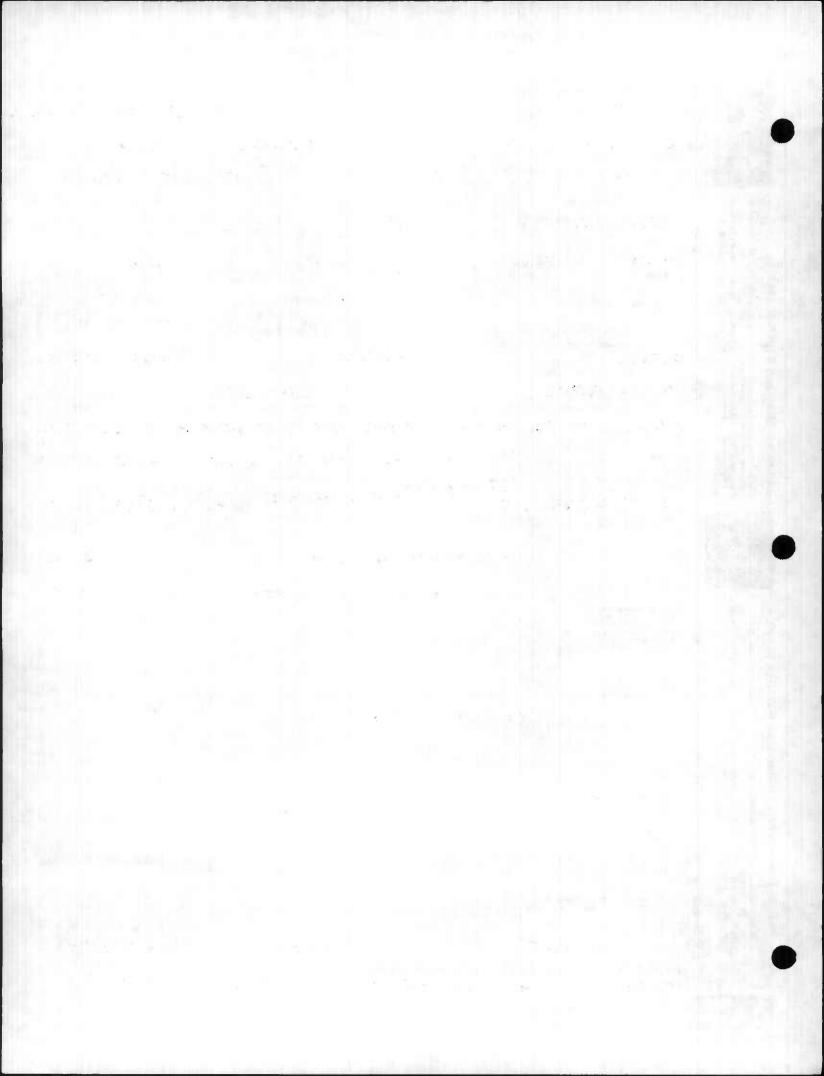
	1 - STATE REGISTRAR	STATE OF MARY		MENT OF I		MENTAL HYGI			
	1. DECEDENT'S NAME (First, Middle, Lat	_				2. DATE OF DEAT MONTH	H DAY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	Tizaluth (041e.			06	26 9	0	11.42
1	178-50-2857	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Yes Aug 8.1	ur)	Country WVa	
~	9a. FACILITY NAME (If not institution, give			9b. CITY, TOWN	OR LOCATION OF DI		9c. COUNT		
СТОЯ	Coffman Nun RESIDENCE OF DECEDENT	sing Home		lagerst	own		Wash	ing	ton
DIREC	10e. STATE 10b. COU		0.	TOWN OR LOCA					10d. INSIDE CITY LIMITS?
FUNERAL I	100. STREET AND NUMBER 10134 Melody I	nington Lane	IHage	rstowr "	f. ZIP CODE 21740		10g. CITIZ USA	EN OF W	HAT COUNTRY?
JNE	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DEC		NIC ORIGIN? (Specif		A RACE	- American Indian,
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYES	2 NO	If yes, sp		in, Pusito Rican, etc		Specif Whi	, White, etc.
ED	15. DECEDENT'S E (Specify only highest gn		16a. DECEDENT'S L	ISUAL OCCUPATION done during me	ON ost of working	18b, KIND OF	BUSINESS/INDU		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homema	retired.)		Hom	Α.		
DMC	17. FATHER'S NAME (First, Middle, Last)		Homemo	INCI	16. MOTNER'S NA	ME (First, Middle, Ma			
EC		r Puf	finburge	r	Eva	ine (not, moore, me		rab	iel
8	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Route Number, City or			
5	Barbara Davis	Daughter	10134	Melody	Lane,	Hagerst			
	20s. METHOD OF DISPOSITION 1 ◯ Burlel 2 □ Cremetion 3 □ Re		b. PLACE AND DATE Of				LOCATION — C		
	4 Donation 5 Other (Specify)		chellsbu				chells		
- 3	21. SIGNATURE OF PONERALISERVICE	CICENSEE		Burne	er Trad	e Servi	ces 10	37D	ual Pla
	23. PART I. Enter the diseases, of	. Durener	MBIS	Hagen	stown,	Md.2174	0		
CATION	immediate cause (final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	ь	A CONSEQUENCE OF						Onset and E
ERTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF	K					
AL C	PART II. Other algorificant condit	iona contributing to death	but not resulting in	the underlyin	g cause given in	Part I. 24a, WA	S AN AUTOPSY	24b.	WERE AUTOPSY FIND
MEDIC							REFORMED?	+	AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO
CIAN:	25. WAS CASE REFERRED TO MEDICAL			26. P	LACE OF DEATH (Ch	peck only one)			
SICI	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Ou		OTHER:		6 Other (Specify,			
¥	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c. IN.	JURY AT	28d. DESCRIBE N		URED	
Y P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU		YES 2 NO				
TED B	3 Suicide 6 Could not 4 Homicide determined	be 28e. PLACE OF INJUF	ty — At home, farm, st ecify)	reet, factory, offic	C6	281, LOCATION (SI City or Town,	treet and Number (State)	or Aural A	oute Number,
Ë	296. CERTIFIER 1 CERTIFYING PH	IYSICIAN: To the best of my kno	wiedge, death occurre	d at the time, date	and place, and due	to the councie) and	menner as state	4	
OMPL	(ma)	IINER: On the basis of sxamineti							and menner se stat
ECC	296. SIGNATURE AND TITLE OF CERTIF				290 LICENSE NU				(Month, Day, Year)
0	SAMUEL	ChAN			1366	55	1.7.	ne 2	6. 1998
5	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF	EATH (ITEM 27) Type.	Print)	. 1	0 1171	11		11100
-	1187 IN/- HI	JUH IN	1774	201100	UN, M	1) 0/14	. 0		
	31. DATE FILED (Month, Dev. Hear)	32. REGISTRAR'S SIG	INATURE S	2	UN, M	1) 0114			



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

-	I. Decedent's Name	a (First, Middle, L	ast)					2. Date		Day	Yaer	3. Tima of De
1	AGNES CAT	HERINE (CROWL					JUNE	-		998	10:25
	la Facility Nama (II	f not institution, g	ive street and number	er)			4b. City, Town,			4c. County		
1	CLEARVIEW	NURSING	G HOME				HAGERS'	LOMN		WASHT	NGTON	
1	5. Social Security N	umber 6.		Age (In yrs.	last birthdey)	If Under 1 Ye	ar If Undar 24 H		of Birth h, Dey, Ye	ear)		ce (State or F
	220-58-44		1□ M 2፴ F	88	Yrs.		110010	12/1	5/19	09	MARYI	
H	Usuel Residenca of 10a. Stata	Decedent 10b. County		100 C#	y, Town or Loc	eation					100	J. Inside City I
						Zation					100	1 Yas 2
⊢	MARYLAND	WASHING	GTON	BOC	NSBORO	1			10	011		Δ
	10e. Street and Nur					10f. Zip Code			10g.	. Citizen of W	mat Country	y'r
_	704 NORTH	MAIN ST					713	40 15 14		U.S.A	America	a la dia a
1	11. Marital Status		12. Was Decede Armed Force	is?	,S. 13. V	Vas Decedant o Yes, specify C	if Hispanic Origin? uban, Maxican, Pu	(Specify Yes erto Rican, etc.	or No-		- Amarican k, White, et	
	1 Nevar Marri	ed 2 Married	1 [Yes 2] If Yes, Giva		1	☐ Yes 2 1	lo Specify:			Specify:	WHIT	15
_	3771 Avidomed		Yaar or Data	s:	100 Doord	antia Mayal On			161	b. Kind of Bu	elegas/lodu	elmi
	(Spec	15. Decedant's l hify only highest g	rade complatad)		(Give I	ent's Usual Ockind of work do. OO NOT use rel	ne during most of t	vorking	101	D. Kind of Bu	3111633711100	Sity
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_	5 YEARS 17. Fether's Name	(First, Middle I as	at)		11011		18. Mother's N	Name (First, M				
L	CARMIE B.		•									
H	19e. Informent's Na				10h Mallin	n Address /Co.	EDNA D.			city or Town	State Zin C	Code)
				פודום								
-	20a. Method of Disp		SON/DAUGH		Place of Dispos	ORTH MA sition (Name of	IN STREE	E, BOOK	ISBOR	O, MAR.	City or Tow	2171 n. State
	MBuriei 2	Cremation 3	Removal from Sta	te C	cemetery, crem	netory or other	olece)					
_		5 Other (Spec					RY JUNE 2	25, 199	OD	OONSBO	KO, M	ARYLAN
	21. Signature of Fu	ineral Service Lica	ansee P. 81	Offel	tok 22		dress of Fecility	7606	OLD :	NATION	TAT DT	VE
	P. STEV	EN DANFE		0	BAS	ST FUNE	RAL HOME			MARY		
t	23a. Part1. Enter the	ha disease, or co	mplications thet cau	sed the deet	h. Do not ente	er the moda of	tying, such as card	liac or raspire	ory arrest	,	1 /	oproximate nterval Betwe
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	Immediate Cause (Myn	CARD	1A1- 11	CARCTIC	1					2 HRS
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ı				NARY		Trav	DISTAS	E				OYRS
	Sequentially list co	nditions	ь. Соже	-	or es e conseq	uence of):	P1301)5	Co-				0 / - 2
	Sequentially list co- if any, leeding to im- cause. Enter Unde Ceuse (Diseese or	nmediate			e take resulted							
15	that initiated events		C	Due to (c	r as a consequ	uence of):						
	resulting in death) l	Last		(
			d							-		
-	Part II. Other slonif	icant conditions	contributing to deat	h but not ree	ulting in the ur	nderlying cause	oiven in Part I.	23b	, Did tobs	acco use cor	ntributa to	the ceuse of
4000	Part II, Other signif		contributing to deat				given in Part I.	23b	The same			the ceuse of (
100	Part II, Other signif		contributing to death				given in Part I.	23b	. Did tobs			
	Part II. Other eignif						given in Part I.	_	1 Yes	2 No	3 ☐ Probe	ably 4☐Ur
	Part II. Other signif						given in Part I.	_	1 🗆 Yes	2 No	3 Probe	e autopsy find lable prior to pletion of cau
1	Part II. Other signif						given in Part I.	_	1 Yes	2 DNo autopsy d?	3 Probe	e autopsy find lable prior to pletion of cau eath?
		SE						24a.	1 ☐ Yes Wes en (performe	2 No	3 Probe	e autopsy find lable prior to pletion of cau
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DHMH 16 Rev 6/95



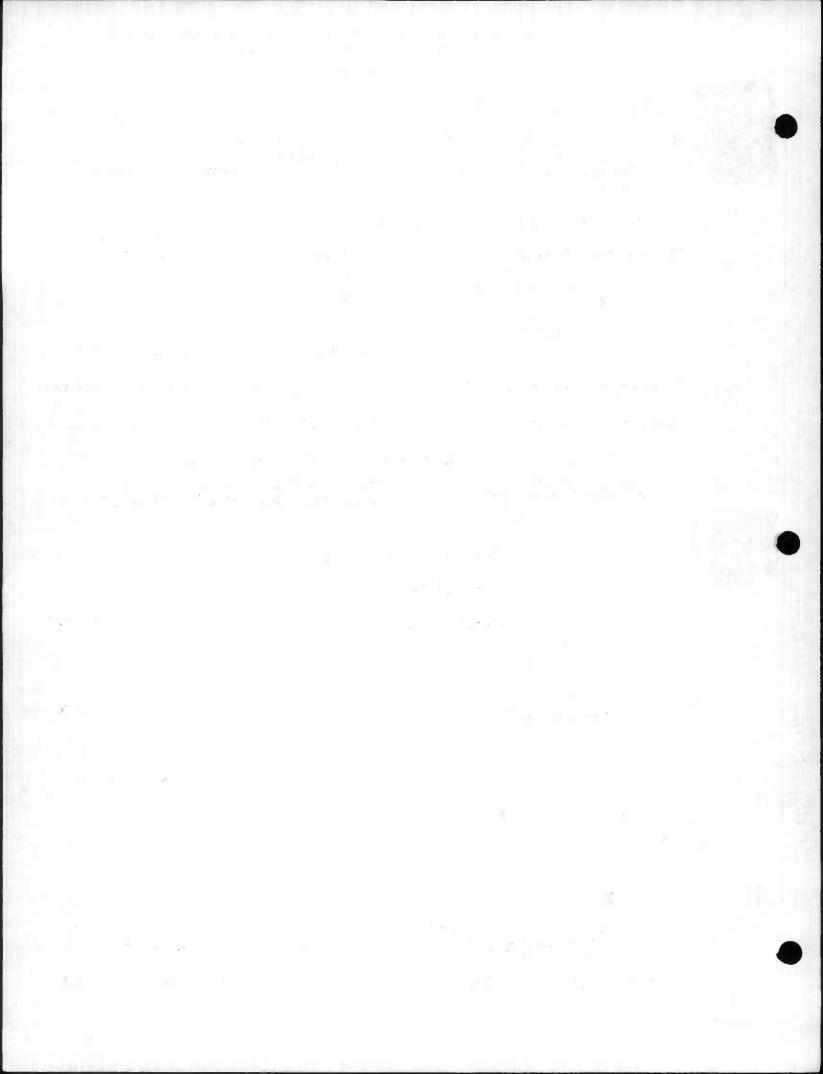
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First Middle | ast) 2. Date of Deeth **Physician** Month PHILLIP CROSS HENRY JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month Day, Year) Jan. 20, 1941 9. Birthplace (Stete or Foreign Country)
Maryland 7. Age (In yrs, last birthday) **Funeral** M 2□ F Days Hours 216-38-0157 57 Yrs Director Usual Residence of Decedent with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 8 435 George Street 21740 238 U.S.A. death Neme 12. Was Decedent Ever in U,S. Armed Forces? 14. Race American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". In page. 1 Nevar Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify Specify: Black by 3 ☐ Widowed 4 M Divorced Completed 15. Decadent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Kitchen Help Country Club 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Clarence Lafayette Cross Elinor Elizabeth Thompson 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) Brenda L. Kline 404 North Prospect Street, Hagerstown, Md. 21740 20b. Place of Disposition (Neme of cametery, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematorium 06+19-98 Smithsburg, Maryland 21. Signature of Funeral Service License Andrew K. Coffman Funeral Home, Inc. R. hoel t 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or haart failure. List only one causa on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediata Causa (Final CEREBROVASCULAR ACCIDENT 5 DAYS disease or condition rasulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner ARTERIOSCLEROSIS 10 YRS. physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): DIABETES MELLITUS 15 YRS. Due to (or es a consequenca of) as use a signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE þ 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Vita Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of this 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 8 To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D-44996 June 16, 1998 30. Name and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Zafar Malik MD 20311 Lappans Road, Boonsboro, Maryland 21713 31. Date filed (Month, Day, Yaar) 32 Ragistrar's Signatura State Wie Davidson Randelle Registrar

DHMH 16 Rav 6/95

Henry



		State of Ma	aryland	/ Depar	tment of	Health and Death		giene g	8	21371
	1. Decedent's Neme (First, Middle, Last	")					2. Date of De			3. Time of Death
an al	Nelson Dallas C					41.00	Month 06	15	98	1:10 a.m.
er			Q				Location of Daath			
_	Western Maryland 5. Social Security Number 6. Se		Cente:		If Under 1 Yea	Hagersto		Washi		
		ØM 2□ F 46	a (myrs. ias		Months Days			1,1952	Cou	placa (State or Foreign intry) y Land
	10a. State 10b. County		10c. City, T	Town or Loca	ition					10d. Inside City Limits
ector	Maryland Washingto	on	Hage	rstown						1 ☐ Yes 2 💢 No
Funeral Director	11109 Lakeside Cou	ırt			10f. Zip Code 21740			10g. Citizen of U.S.A.	What Cou	intry?
Ine	11. Marital Sfafus	12. Was Decedanf & Armed Forces?	var in U,S.	13. Wa	as Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yas or No-	14. Rac	ce - Amari	can Indian,
by	1 🔀 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Yaar or Dates:	ło		Yes 2⊠No		10 1 110411, 010.7	Specif		ite
ted	15. Decedent's Edu		1	6a. Deceder	nt's Usual Occi	pation	41	16b. Kind of B	usiness/Ir	ndustry
Completed	(Specify only highest grad Elementery/Secondary (0-12)	Cottege (1-4or 5	+)	life. DC	na of work done NOT use retir	e during most of wo				
Con	12		,	Carpen	iter			Weather	proo	fing Comp.
3e (17. Father's Neme (First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden Sumar	ne)	
To Be	Harold Carpenter					Dorothy	Ward			
-	19a, tnforment's Name/Relationship (Ty	rpe, Print)		19b. Mailing	Address (Stree	et and Number or F	lural Route Numbe	er, City or Town	, State, Zi	p Code)
	Dorothy Ward Griffi	ith/ Mothe	er	11109	Lakesi	de Court	Hagerst	own, Mar	ylan	d 21740
	20a. Method of Disposition 1 ☐ Burial 2 【②Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				ion (Name of tory or other pl		Data 15,1998	20c. Location	_	own, Stafe , Maryland
	23a. Part 1. Enter the disease, or complished, or heart feilure. List only or timmediate Cause (Finet disease or condition resulting in death)	. Termi	inal c	133 Do not enter	of pane	ring, such as cardia	N. Hag	erstown	n,Mar	yland 21742 Approximate Interval Between Onset and Death 15 days
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	0		s e conseque						
sici	Part II. Other significant conditions cor	nfributing to death bu	t nof rasultin	ng In the unde	erlying causa g	ivan in Part I.	23b. Did t	obacco use co	ntribute t	to the cause of death?
y Phy	Alcohol abuse						101	Yes 2 XNo	3 □ Pro	babty 4 Unknown
pieted I							24a. Wes	an autopsy med?	a\	Vere autopsy findings valiable prior to propletion of cause death?
Son							101	es 2 No	1	☐Yes 2 No
o Be	25. Was case referred to medical exeminer?	lospital: 1 🛣 Inpatier	* 20EB	/Outpations	2000	thor:	eth (Check only o		(0	4.1
⊢	27. Magner of Death			Outpatient b. Time of	3LI DUA	4 Li Nursing	Home 5 Resid		- , ,	ry)
cation	1 Natural 5 Pending Investigation	28a. Date of tnjun (Month, Day	Year)	Injury	28c. Inje W	ork? □Yes 2□No				
edicai Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Inju building, etc.	ry - At home . <i>(Specify)</i>	e, ferm, street	t, factory, office		28f. Location (S City or Tow	Street and Numi m, State)	ber or Aur	al Routa Number,
dicai	29a. Certifier (Check only one) 1 Certifying Physical Cartifying P	alcian: To the best of ner: On the basis of and manner state	examination	dge, death or and/or inves	ccurred et the t stigation, in my	ime, date and ptac opinion, death occ	e, and due to the ourred at the time, o	cause(s) and made and place,	anner as s	stated. to the cause(s)
Me	29b. Signature and little of certifier	//			29c. Licar	ise number		29d. Date signa	d (Month,	Day, Year)
	frank	Indied	0		D2	7898		6/1	/98	
	30. Name and address of person who co	empleted cause of de	ath (ttem 23	Be) (Type, Pri	int)					
	Francisco L. Andra	ade 350 Mi	11 St	reet.	Hagers	town. Mar	vland 2	1740		

State Registrar 31. Date filed (Month, Day, Yaz)

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified as

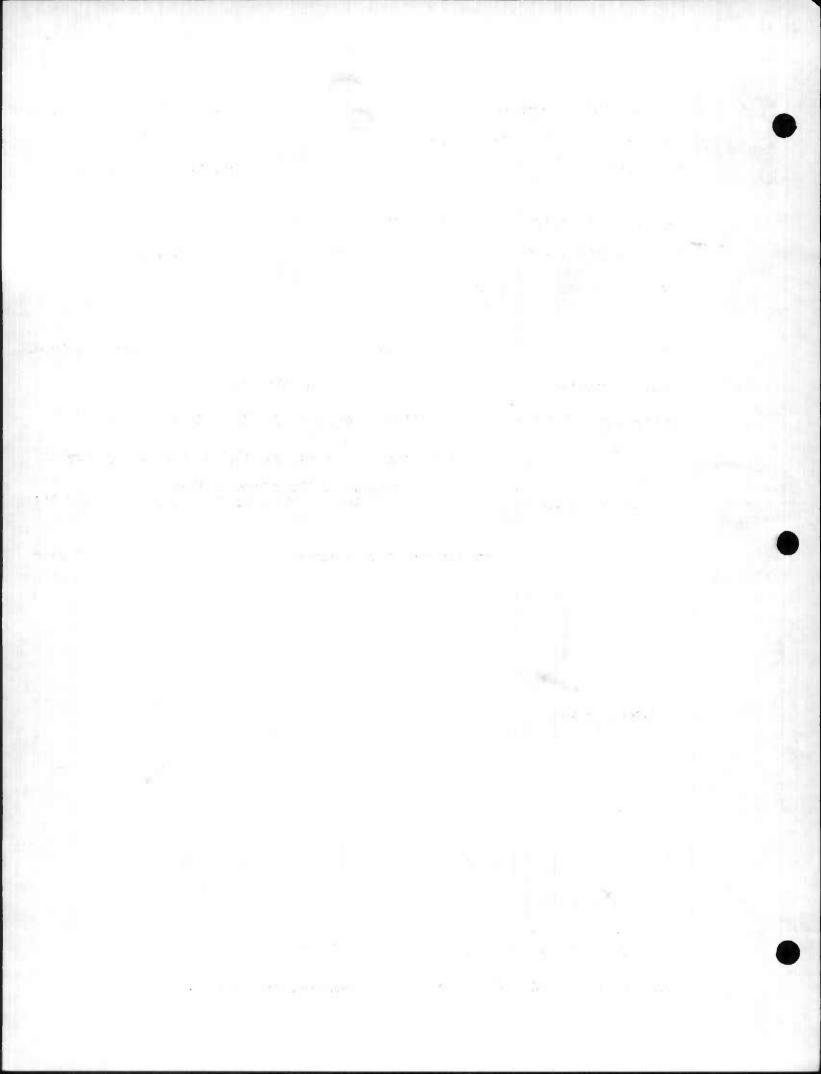
Physician /Medical Examiner

To the Hospital or Attending Physician: The lew requires that the death certificeta be executed within 24 brous after death.

To the Funeral Director: After this certificata hes been signed by the ettending physician end completely filled in by the funeral director, paga 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10122 PM 1998 **Physician** ALTON BYRON June CARTER 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Min. 1√2 M 2□ F Months Hours 219-05-2074 Director 81 Dec. 28,1916 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygians. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, he health 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 □ No Directo Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1329 Salem Avenue 21740 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2X No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Fuel Service Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Carter Amelia Turner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Peggy Carter/ Wife 1329 Salem Avenue Hagerstown, Maryland 21740 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery June 16,1998 Hagerstown, Maryland 22. Name and Address of Facility 21 Signature of Funeral Servica Licensee Douglas A. Fiery Funeral Home www. 1331 Eastern Blvd. N. Hagerstown, Md. 21742 Approximate Interval Between Onset and Death 23a Part Enter the deease or complications that cause the death. Do not enter shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Mouth Metastalie. concinoma Examiner birter, Alton 18410 Physician/Medical Examine Nexterle 1-2 Ups attanding physician and I for use as the bunal-trensit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

been signed be should be deta ata hes t this cartificata director. Aftar Director: /

þ

Completed

Be

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Certification:

edical

1 ☐ Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of deeth?

1 ☐ Yes 2 100 26. Place of Death (Check only one)

	-	Describe how in		
Nursing	Home	5 Residence	6	Other (S

Other: 4 2 ER/Outpatient 3 DOA 28c. Injury at Work?

1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

TSC Certifying Physicfan: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of cartifier

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a, Certifier

4 Homlcide

29c. License number

29d. Date signed (Month, Day, Year)

Harved RIulin 9

5 Pending investigation

6 Could not be determined

6-13.95

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1) Inpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

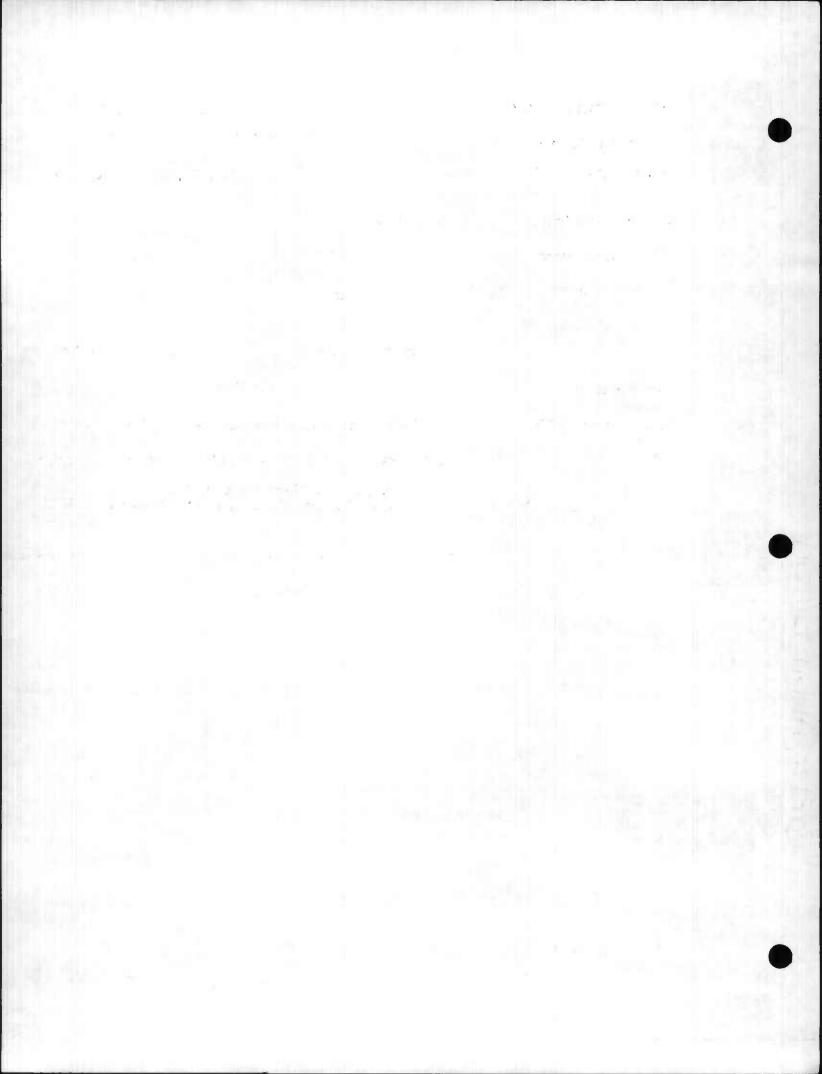
MA 10 R. Tritih HAROLD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

1211 ST HAGOSSIDWA Md. 21740 345 Julie Davidson-Randelle

State Registrar

within 24 hours eff To the Funeral DI completely filled in

the Hospital or Attanding Physician:

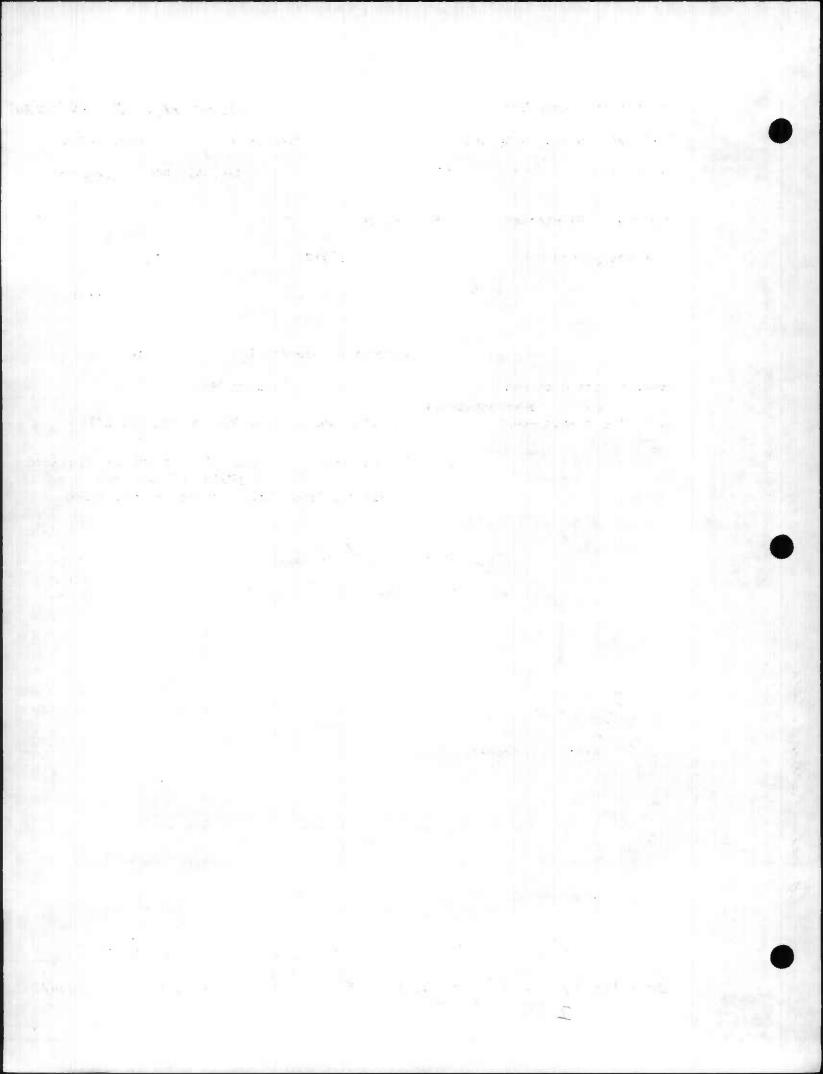


State of Maryland / Department of Health and Mental Hygiene

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			$C\epsilon$	ertificate o	f Death		Reg	No.		
	1. Decedent's Name (First, Middle, La	ast)					of Death	Davi	Vees	3. Tima of Death
Physician /Medies!	Richard Earl Car	nahan				JU		11,19	98	10:05 AM
/Medical Examiner	4a Facility Nama (If not institution, git Washington Count	the second second second				wn, or Location o		4c. County		
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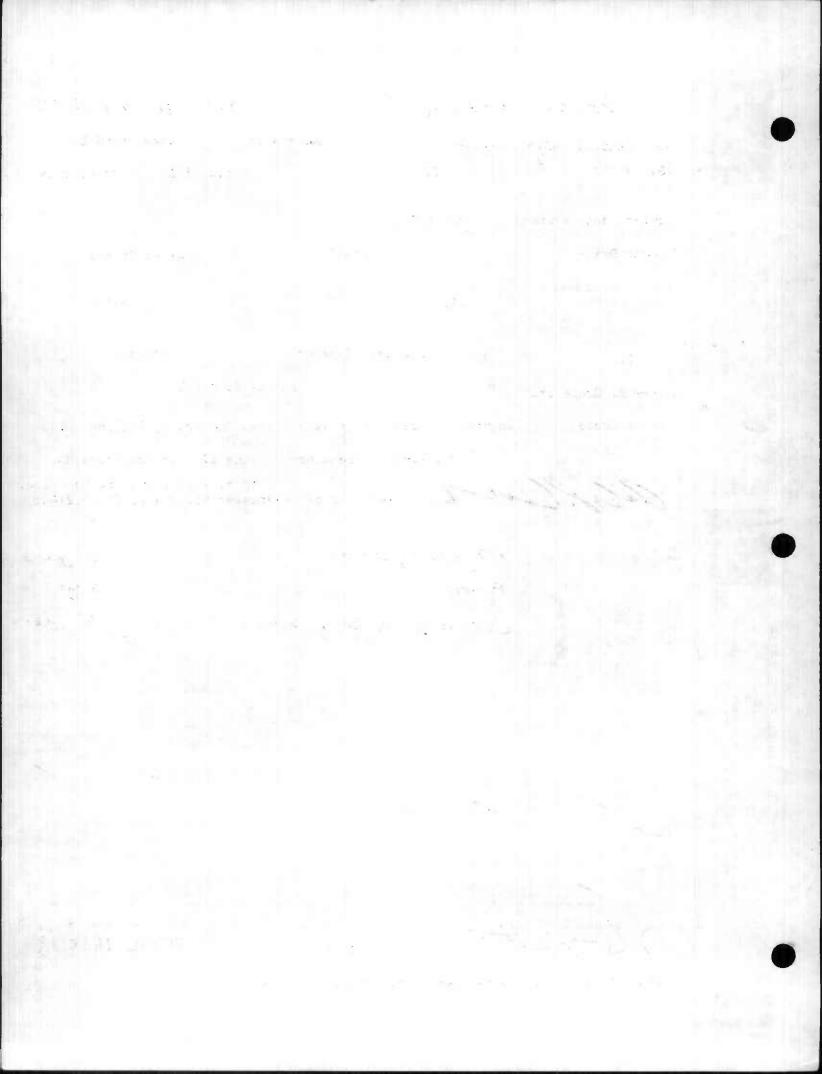
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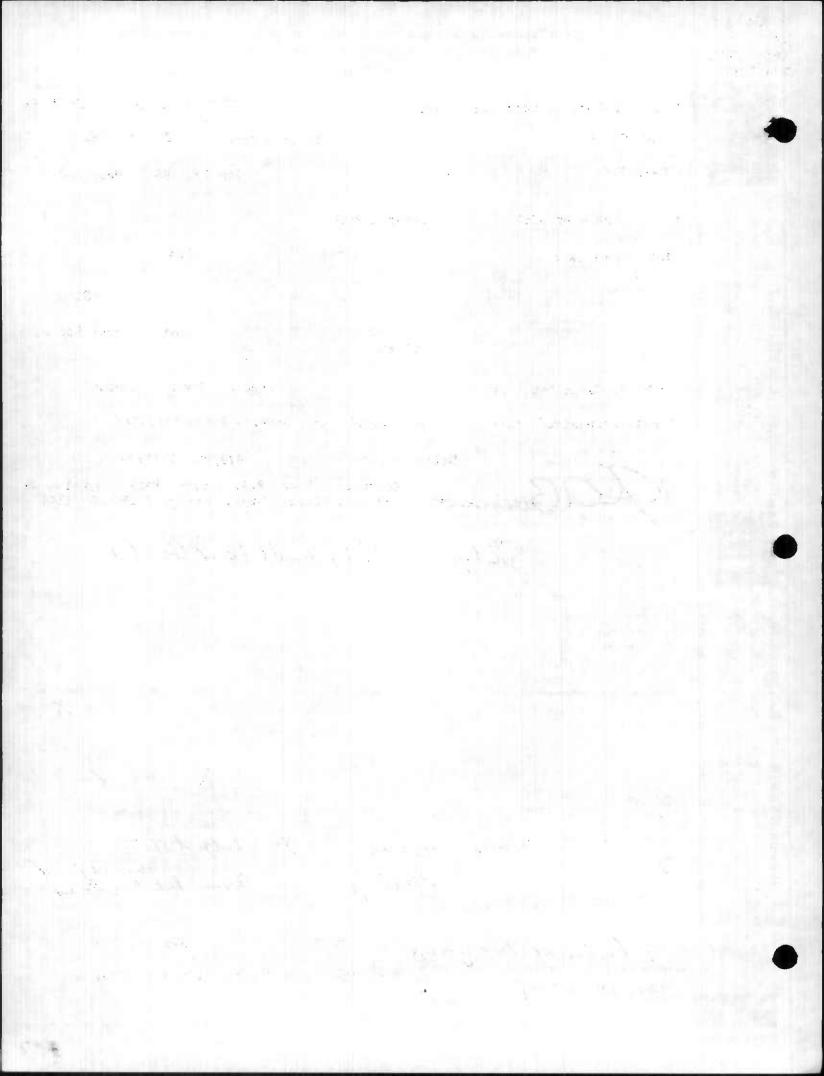
30. Nema and eddrass of person who complated cause of death (Itam 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

JUNE 08, 1998

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 16 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Month Day Yes **Physician** 6:30 A.M. ARTHUR CASAGRANDE 1998 JUNE 25 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not Institution, give street end number) Examiner 31019 WILTON AVE. SALISBURY WICOMICO If Under 1 Yeer 8. Date of Birth (Month, Day, Year) FEB. 12, 1910 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplace (Stete or Foreign **Funeral** Deys Min 1**X** M 2□ F Months Hours Yrs. 88 AUSTRIA Director 140-10-0712 Usual Rasidence of Decedent 10a, State 10d. Inside City Limits r 28a-f show notified at 10b. County 10c. City, Town or Location the Marylan 1 Yes 2 No Director SALISBURY MD WICOMICO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or Items 23a or the Medical Examiner must be 21804 31019 WILTON AVE. U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritet Stetus filed within 72 hours after 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE Baltimore, Maryland 21215-0020 þ 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedanl's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 FOUNDRY WORKER FOUNDRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) å 8 and Mental marked o Pages 1 and 2 should 2 **AMADUS** CASAGRANDE AMALIA THOMASOLI 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trax 9058. . MARY CASAGRANDE - WIFE 31019 WILTON AVE. SALISBURY, MD 21804 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Slate 20e. Method of Disposition Dete 1 N Buriat 2 ☐ Cremation 3 ☐ Removal from State SPRINGHILL MEMORY GARDENS 6-27-98 4 Donation 5 Other (Specify) HEBRON, MD 22. Name end Address of Facility ra d Funeral Service Licensee 705 E. MAIN ST. SALISBURY, MD 21804 uala BOUNDS FUNERAL HOME auni Approximete Intervat Between Onsat and Death Part1. Enter the disease of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Ust only one cause on each line. **Physician** /Medical Immediata Ceusa (Final diseesa or condition resulting in deeth) Examiner Dua to (or as a consaguance of) Examiner physician and the burief-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es a consequence of) attending p signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 3 Probably Unknown 1 Yes 2 No þ 24b. Wera eutopsy findings available prior to been si 24e. Was en eutopsy Completed completion of cause of death? certificate has b 2 No 1 Yas 2 No 1 Yas or Attending Physician: director, Be 25. Was casa raferrad to medicet axaminar? 26. Placa of Daeth (Check only one) 2 No Othar: 4 ☐ Nursing Homa 5 🏋 Residanca 6 ☐ Other (Specify) To 1 Yas 1 | Inpatiant 2 | ER/Outpatient 3 | DOA this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Affer Natural 2 Accide 5 Pending 1 Yas 2 No death. Investigation Accident after death Director: / d in by the f 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida in 24 hours aft the Funeral Di pletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 \$ 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 0

Registrar

HUDDLESTON, M.D. 106 CHRISTJON 31. Date filed (Month, Dey, Year) JUN 26 1998

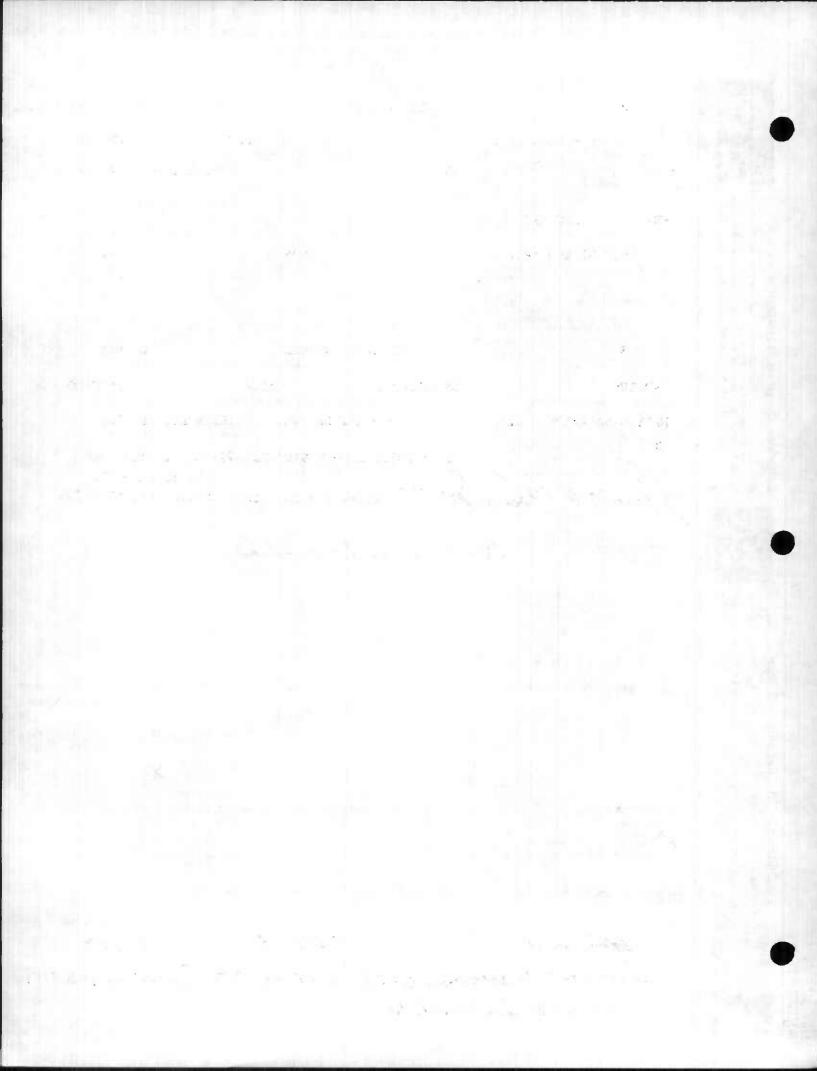
30. Nama and addrass of parson who complated cause of deeth (ttam 23a) (Type, Print)

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32. Registrar's Signatura

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MILFORD ST. SAUSLING, MD 21704



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day N/M/NROGERS CHAMBERS JUNE 26,1998 9:55 P.M. 4b. City, Town, or Location of Death 4e Facility Nama (If not institution, give street and number) 4c. County of Death SOUTHERN MARYLAND HOSPITAL CENTER PRINCE GEORGE CLINTON Hours Min. JAN 23, 1961 7. Aga (In yrs. lest birthdey) If Undar 1 Birthplaca (Stete or Foreign Country) 5. Social Security Number 6 Sax M 2□ F Months Deys 37 WASHINGTON, DC 577-90-6454 Usual Rasidence of Decedant 10d. Insida City Limits 10a State 10h County 10c. City. Town or Location 1 ☐ Yas 2 → No MARYLAND ST.MARY'S LEXINGTON PARK 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? APT.#624 45960 INDIAN WAY 20653 U.S.A. 12. Wes Dacedant Evar In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva A Yaar or Detas: 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Collega (1-4or 5+) Elamentary/Secondary (0-12) YEARS MANAGER FAST FOOD STORES 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middle, Last) SANFORD CHAMBERS MARY REAVES RANSOM 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Neme/Relationship (Type, Print) ANDREA D. CHAMBERS-SPOUSE SAME AS #10 20e. Method of Disposition 20b. Plece of Disposition (Neme of cametary, cramatory or other place) Data 20c. Location - City or Town, State Burial 2 Cremation 3 Ramovel from State 4 Donation 5 Other (Specify) HERITAGE MEMORIAL PARK 7-2-98 WALDORF, MARYLAND 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line. Do not enter the moda of dying, such es cardiec or respiratory errast, Immediata Causa (Final diseese or condition rasulting in daath) Due to (or as a consequence of) Due to (or es a consequança of): Sequantially list conditions, if any, leading to immediata causa. Enter Underlying Causa (Disaasa or Injury thet initieted events rasulting in daath) Last Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to deeth but not resulting In the underlying cause given in Pert 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Was an autopsy 2 19 No 1 T Yes 2 No 1 Yas 25. Was case raferred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Mpatiant 1 Yes 20 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 5 | Pending 1 Yas 2 No Investigation 2 Accidant 6 Could not be determined 3 Sulcide

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Examine Physician/Medical P Completed Be 2 funeral Certification: hours after death filled in by 24 hours Medical

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Hygiene.

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Department of Important: If any injury or

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Baltimore,

4 ☐ Homicide

(Check only one)

29a. Cartifiar

29b. Signatura and title of cartifiar

1 Certifying Physician: To tha best of my knowledga, daath occurred et tha time, dete and placa, and due to the ceuse(s) and mannar as steled.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, data and pleca, and due to the cause(s) and mannar steled. 29c. Licansa number

29d. Data signed (Month, Day, Year)

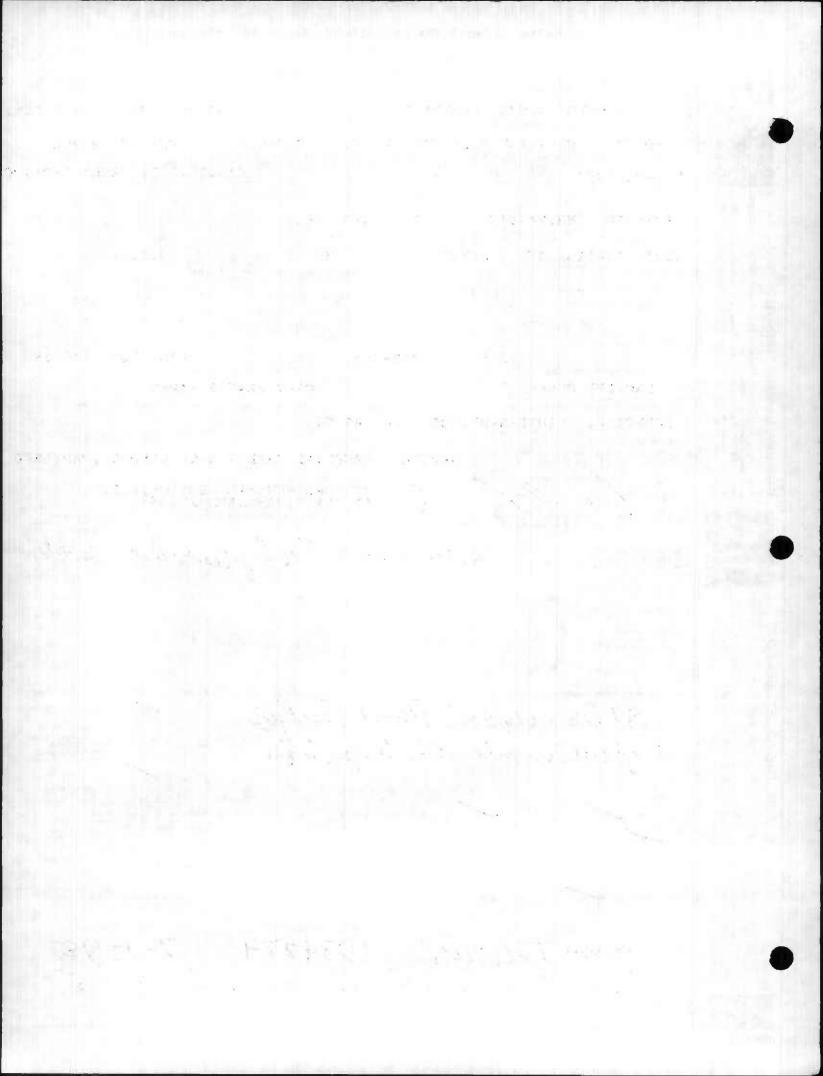
Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

32. Registrar's Signatura

28e. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify)

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** June 30,1998 11:51A JAMES ROBERT COLES, SR. /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Civista Medical Center La Plata Charles If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 6. Sex 1 2 M 2 □ F 5. Sociei Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** SEAVIEW VIRGINIA Yrs. 227-52-5391 Director JULY 26,1941 56 Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 No Director MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6325 HAWTHORNE ROAD 20646 UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No 1959— If Yes, Give Yeer or Detes: 1962 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. traumatic event, the Medical Examiner. 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1962 BLACK Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4 YEARS EEO SPECIALIST FEDERAL GOVERNMENT 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be CARLISLE JAMSON COLES MARY FISHER COLES 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN E. COLES / WIFE 6325 HAWTHORNE ROAD, LA PLATA, MARYLAND 20646 20e. Method of Disposition 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from Stete ŏ 4 ☐ Donetion 5 ☐ Other (Specify) HUNTT CREMATORY 7/6/98 WALDORF, MARYLAND 21. Signature of Funerel Service Licensee

22. Name end Address of Fecility
THORNTON FUNERAL HOME, P.A.

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THORNTON FUNERAL HO 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** and 10 /Medical Immediate Cause (Final diseese or condition resulting in deeth) monou Examiner Due to (or es a consequence of): Physician/Medical Examiner physicien and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): thet Initieted events resulting in deeth) Lest Due to (or as e consequence of) ettending p Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were autopsy findings Completed 24e. Wes en autopsy performed? eveileble prior to completion of cause of deeth? page 2 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 10 Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 No 1 Yes 27. Manper of Deeth 28e. Dete of Injury (Month, Day Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: Netural 5 Pending investigation 24 hours after death.

Person of the Funeral Director: After the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the further the f 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suidide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 61040LD BRANGHAVETEMPLEHILL MD EMRY 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signeture State Ilia Daviden Rondall JUL 0 2 **1998**

Registrar

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reportant: If item 27

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The law requires that the deeth certificate be executed

Box 68760.

P.O.

Division of Vital Records,

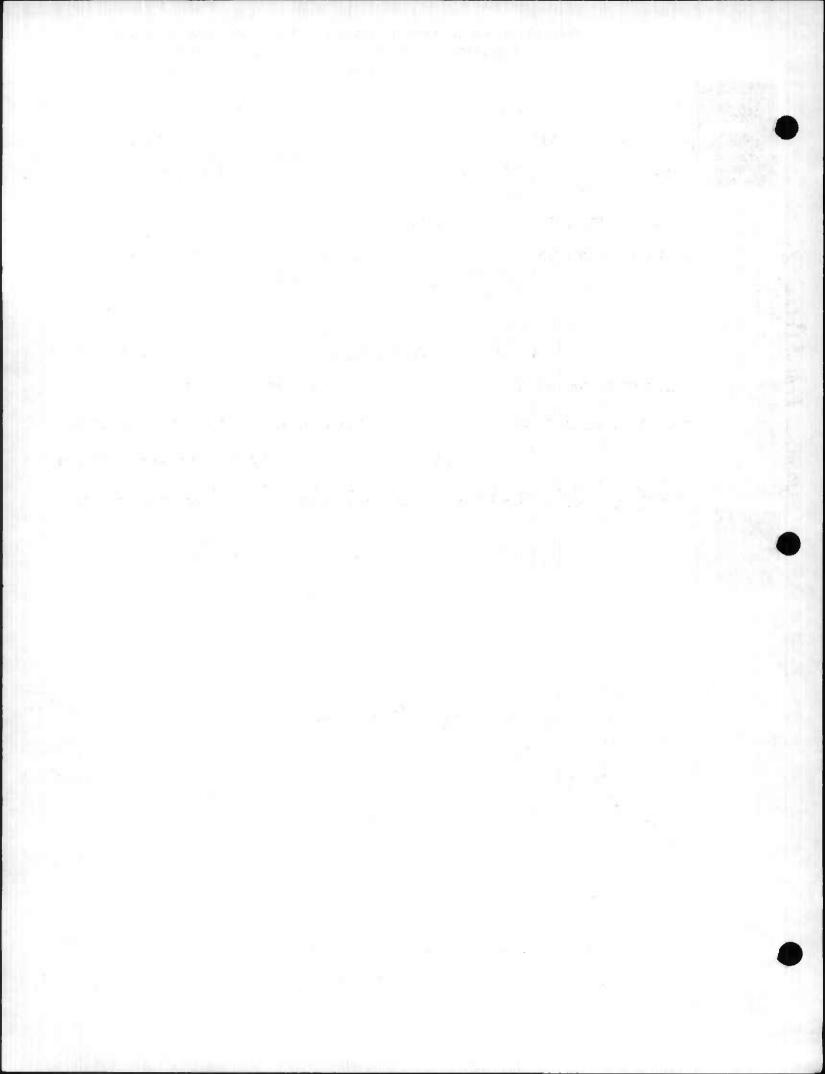
or Attending Physician:

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altimore, Maryland 21215-0020



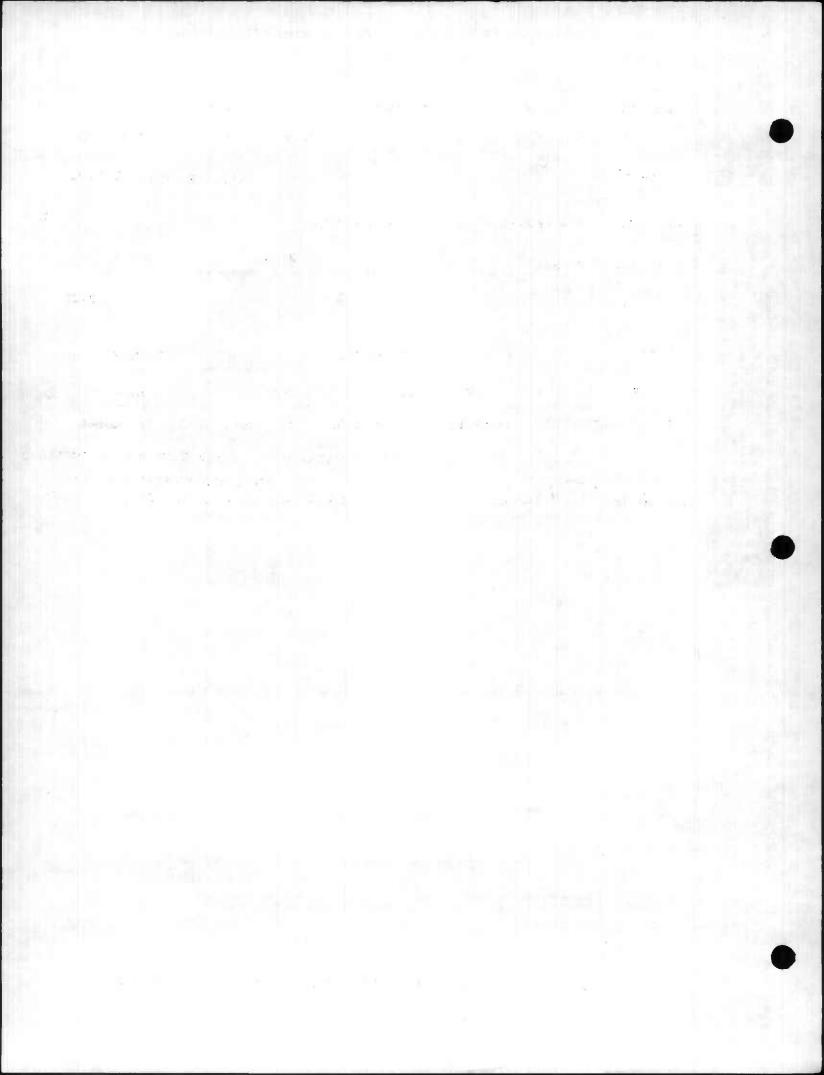
State of Maryland / Department of Health and Mental Hygiene STEPHEN ANTHONY CAPILONGO ITEMS #23 PART I, 27, 28A-F PER MEO FILM G761 7-14-98 WR Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 3, Day 1998 **Physician** JULY 2012 PM STEPHEN ANTHONY CAPILONGO, JR. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner GLEN BURNIE 614 WELLHAM AVENUE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys XXM 2 F Months Hours 212-54-9212 **Director** OCT. 12, 1953 MARYLAND Usual Residence of Decedent the Marylend x 28a-f show 10e. Stete 10b. County 10c, City, Town or Location 10d, fnside City Limits 1 Yes 2 No Directo MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ma 23a or death with 11. Maritel Stetus

12. Was Decedent Ever in U.S. Armed Forces?

1 Never Merried 2 Merried

1 Ves 2 No If Yes, Give Year or Detes: 21061 U.S.A. Funeral "natural", or items edital Examiner m Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. Bleck, White, etc. filed within 72 hours efter Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE þ Completed 7 is marked other than "nature traumatic event, the Medical 15 Decedent's Education 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Hygiene. Elementery/Secondary (0-12) 11 N/A MAINTENANCE AVIATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Pages 1 and 2 should be family and Mentel I STEPHEN CAPILONGO, SR. MARY BROWN 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) item 27 it other tr MARY R. CAPILONGO (MOTHER) 614 WELLHAM AVENUE, GLEN BURNIE, MD. 21061 20b. Piece of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from State 7/7/98 GLEN BURNIE, MARYLAND GLEN HAVEN MEMORIAL PARK 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fungual Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA., OKan 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 234 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart feilure. List only one cause on each line. **Approximate** Interval Between Onset end Death **Physician** Immediate Ceuse (Finel diseese or condition resulting in deeth) /Medical a. ACUTE NARCOTIC INTOXICATION Examiner Due to (or es e consequença ot): Examiner physician and s tha burial-transit the death certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): 238 950 detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 0 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown signed t Records, by 24b. Were eutopsy findings eveilable prior fo completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peen certificate has b irector, page 2 s 1 PYes 2□No 1 PYes 2 No Division of Vital 25. Wes case referred to medical examiner?
XXX Yes 2 □ No Physician: Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28e. Dete of Injury (Month, Day Year) FOUND 7-3-98 28b. Time of Injury P 27. Manner of Deeth 28d. Describe how Injury occurred 28c. Injury at Work? After Attending 5 Pending Investigation 1 Naturel efter death. Director: Af 1 Yes 2 No UNKNOWN 2 Accident a 24 hours efter dea Me Funerel Director bletely filled in by th 6 K Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number City or Town, Stete) 614 WELLHAM AVENUE GLEN BURNIE, MARYLAND 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
FOUND AT HOME 4 Homicide b Hospital 1 Certifying Physicfan: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner stated. 29e. Certifier edical completely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) JULY 5, 1998 O.C.M.E hute w 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 huteno ennis 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 1998 I wha Davidson -Randell Registrar

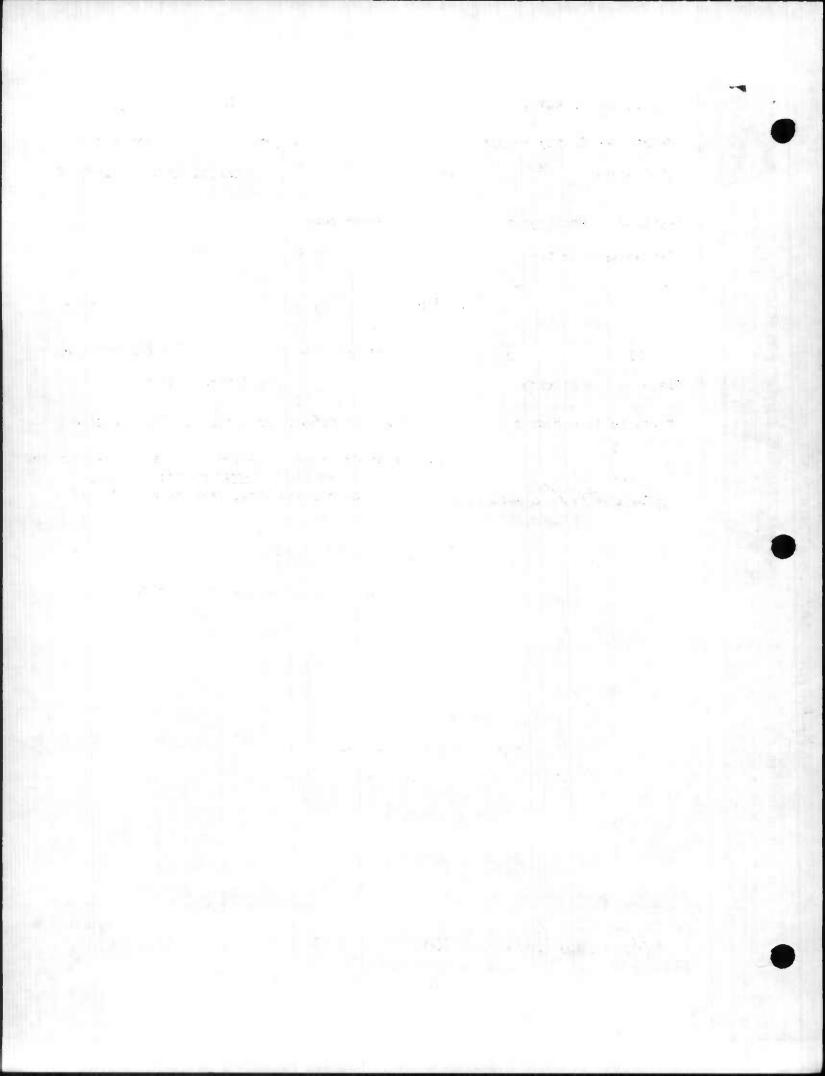


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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		Funeral	5. Social Security N			a (In yrs. la	ast birthday)	If Under 1 Year Months Days			th av. Year)	9. Birthp	place (Stata or Foraign
		Director	212-24-29	987	10X M 2 F	69	Yrs.	monaro ou yo		Oct.31	1,1928		ryland
		2 -	Usual Residence of			10a Cibu	, Town or Lo	ention					10d. Inside City Limits
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		S M S M	Maryland		ngton			Hagersto	wn				
		the series	10e. Street and Nu					10f. Zip Coda			10g. Citizen of 1		ntry?
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		ther death with the Ma r Herre 23a or 28a4 a siner must be notified Funeral Director	11. Marital Status		12. Was Decedant Armed Forces?		S. 13.	Was Decedent of I If Yas, specify Cub	Hispanic Origin? ban, Maxican, Pu	(Specify Yas or No erto Rican, atc.)	D- 14. Rad Blad	ce - Amaric ck, Whita,	can Indien, atc.
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0		law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transit apieted by Physician/Medical Examiner	Sequantially list co	Sequantially list conditions, eny, leading to immediata eusa. Enter Underlying cause. [Diseass or Injury c.									
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-	o	hat the death ed by the atter detached for Physicia	Part II. Other eignit	ficant conditions	contributing to death b	ut not rasu	Iting In tha u	ndarlying cause g	iven in Part I.	23b. Dld	tobacco use co	entribute t	o the cause of death?
+	9	d by Jetac		diape	tis mell	itus				1□	Yes 2□ No	3 ☐ Pro	bably 4 Unknown
01	S	signe be of					0.	S.				045 141	/ara autopsy findings
4	Division of Vital Records	The law requires that th sate has been signed by page 2 should be detacCompleted by Phy		End	Shacer	end	fai	line		24a. Was	s an autopsy ormed?	av	vailable prior to
	ec	las b		10	1	4		E.1.				of	death?
	<u>—</u>	certificate has rector, page 2		Com	eshre	lie	and	Tai U	re	10	Yes 2 TINO	1	□ Yas 2□ No
	ita	slan: entific ector,	25 Was case refer	rred to medical						aath (Check only	one)		
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	0	Attending Physician: or death. ector: After this certific by the funeral director, iffication: To Be (27. Mannar of Deat	h 5 ☐ Pending	28a. Data of Inju (Month, De	ry y Year)	28b. Tima o	28c. Inju	ury at ork?	28d. Dascribe	how injury occur	rred	
	Oic.	oath. v: Af	2 Accidant	invastigation	on			M 1]Yas 2□No				
1	N N	tal or Attending Para after death. al Director: After ted in by the funers Certification:	3 ☐ Suicida 4 ☐ Homlcida	6 Could not l	28e. Place of Inj	ury - At ho	ma, farm, st	raat, factory, office			(Street and Num. iwn, Stete)	ber or Run	ral Routa Number,
	0	Cer in Cer											
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			30. Name and addr		completed cause of d	eath (Item	23a) (Type,	Print)	11 1	110	21742		
			BAPURA						magento	im Mo	CITTL		
		State	31. Data filed (Mon	th, Day, Year)	32. Registr		idson-R						
		Registrar		JUL UA I	330 gw	ia Day	10000-1	indelle					



8-3502-04 RRY DOUB		Please	Type or Pri State of M		d / Depa	artment	t of h	Health and		_	ble.	1201
CDC					Cei	tificate	9 01	Death	1	Reg. No.	0 6	1301
Physician	1. Decedent's Name								2. Dete of De Month	Dev	Yeer	3. Time of Death
/Medical		A. Doul						4b. City, Town, or	JUNE		1998	1622 P
Examiner	4a Fecility Name (If WASHING	TON COU	VTY HOSP					HAGERST	OWN	WASH	INGTO	
Funeral Director	5. Social Security No. 164-64-8	8859	7. A	14	lest birthday) Yrs.	If Under Months	Days			ey, Year)	9. Birthpi Count Penn	ece (Stete or Foreign try) sylvania
72 hours enter death with the Meryland netural, or items 23s or 28s-f show dical Examiner must be notified at eted by Funeral Director	10a. State	10b. County	•		y, Town or Lo						10	od. Inside City Limits
or 28a-fa be notified Director	Pa.	Frankl:	ın	Mer	cersb	10f. Zip	Codo			10g. Citizen of V	What Count	in(?
Dir.			ı				236	<u> </u>		U:S		ay r
e 23	3599 Let	mar Koad	12. Was Decedent	Ever in 11	C 12 1				Procify Ves or N		e - America	an Indian
at, or items 23s or 28s-f show Examiner must be notified at by Funeral Director	11. Maritel Status 1 ☐ Never Marrie 3 ☐ Widowed		Armed Forces: 1 Tes 2 3 If Yes, Give Year or Dates:			f Yes, spec		Hispanic Origin? (Seen, Mexican, Puer Specify:	to Rican, etc.)	Blac Specify	k, White, e	etc.
"natural", adical Exp		15. Decedent's Ed			16a. Deced	dent's Usue	1 Occu	pation	1.	16b. Kind of B	usiness/ind	lustry
	(Speci	ify only highest gre	de completed) College (1-4or	54)	(Give	kind of wor DO NOT us	rk done se retire	pation during most of wo ad)	rking	T 1		
THE CO	8	10019 (0-12)	Conage (1-401	54)	Stud	lent				Educa	tion	
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Menta arked atic ev	Clair	Double					Audrey Keebaugh					
and Mental Hyglene. Is marked other than sumatic event, the M To Be Comp	19a. Informent's Na	me/Reletionship (1	Type, Print)		19b. Mailir	ng Address	(Stree	t end Number or R	urei Route Numi	ber, City or Town,	Stete, Zip	Code)
am 27 la	Audrey	Double	-Mother		3599	Lem	nar	Rd., M	ercers	burg, F	a. 1	7236
If itam 27 is marked other than or other traumatic event, the M To Be Comp	20a. Method of Disp	osition			lece of Dispo	sition (Nem	ne of		Date	20c. Location -		
Important: If it any Injury or o once.		☐ Cremetion 3 ☐ 5 ☐ Other (Specify	Removal from State					metery	6/23/9	8 St. T	homa	s. Pa
important: If item 27 any injury or other ti once.	21. Signeture of Fur				22	Name an	d Addre	ess of Facility				
any pnc	4/	. //	1		K	Kelso	- C	orneliu	s Fune	ral Hom	e, I	nc.
_	Congression Constitution	e cor	sligations that cause	d the deat	b Do sol oot	492	L.V	W.W., S	t. Thor	mas, Pa	. 1/	252 Approximete
	shock, or hear	t feilure. List only	olications that cause one ceuse on each l	ine.	n. Do noi en	er the mod	e or dy	ing, such es cardia	ic or respiratory	onest,		Interval Between Onset and Deeth
sician edical	Immediate Cause (I	Finel	humpur tryphics									
niner	diseese or condition resulting in death)		e. MUC	1 1/100	Da	JURI	62					
				Due to (c	or es e consec	quenca of):						
ial-transit			b								i	
I-trar	Sequentielly list con if eny, leading to im	nditions, mediete		Due to (o	r es a consec	uence of):						
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by the ettending physicached for use es the Physician/Medic											- 1	
hed hed	Pert II. Other signifi	cant conditions co	ontributing to deeth t	out not res	ulting in the u	nderlying c	ause gi	iven in Part I.	23b. Dfc	tobacco use co	ntribute to	the cause of death?
									1	Yes 2 No	3 Prol	bably 4 Unknow
£ 2 6									04- 144-		24h W	ere autopsy findings
page 2 should										s an autopsy formed?	ave	eileble prior to
mpie									}		of	death?
page Com									1	Yes 2 No	10	346s 2□ No
certificate rector, pay	25. Was case referr	ed to medical						26. Place of De	eth (Check only	one)		
5 0	1 X Yes 2 □	No	Hospitei: 1 🗆 Inpati	ent 2 🗆	ER/Outpatier	nt 3ČX DC	OA O	ther: 4 Nursing	Home 5 ☐ Res	sidenca 6 🗆 Oth	er (Specif	y)
After th funeral	27. Menner of Deeth		28e. Dete of Inj (Month, De		28b. Time o	2	8c. Inju	ury et ork?		how injury occur		
tor: Aft the fur icatio	1 Natural 2 Accident	5 Pending investigation	6 19	98	315	РМ	1	Yes 2 No	DASS EXT	un 1 w as	R, ST	rual Their
the Funeral Director: After the mpletely filled in by the funeral Medical Certification:	3 ☐ Sulcide 4 ☐ Homicide	6 Could not be determined	28e. Pleca of In	jury - At he	ome, ferm, str	eel, factory	, office		28f. Location City or To	(Street and Numi	ber or Rura	I Route Number,
d in d	- I Homicide		building, 6		SOWA	7			WELCH	PO PEW	SYLW	- Aire
the Funeral Director: npletely filled in by the Aedical Certifical	29a, Certifier	1 Certifying Ph	yelclan: To the best	of my kno	wledge, deatl	occurred	et the t	ime, dete end plac	a, end due to the	e cause(s) end m	anner as s	tated.
pletely fill	(Check only one)	2X Medical Exam			tion end/or in	vestigation,	, In my	opinion, death occ	urred at the time	, date end pleca,	and due to	the cause(s)
or the Funeral Dompletely filled										Dey, Year)		

To the Hospital or Att within 24 hours efter d To the Funeral Direct completely filled in by

29b. Signerare and title of cartifier

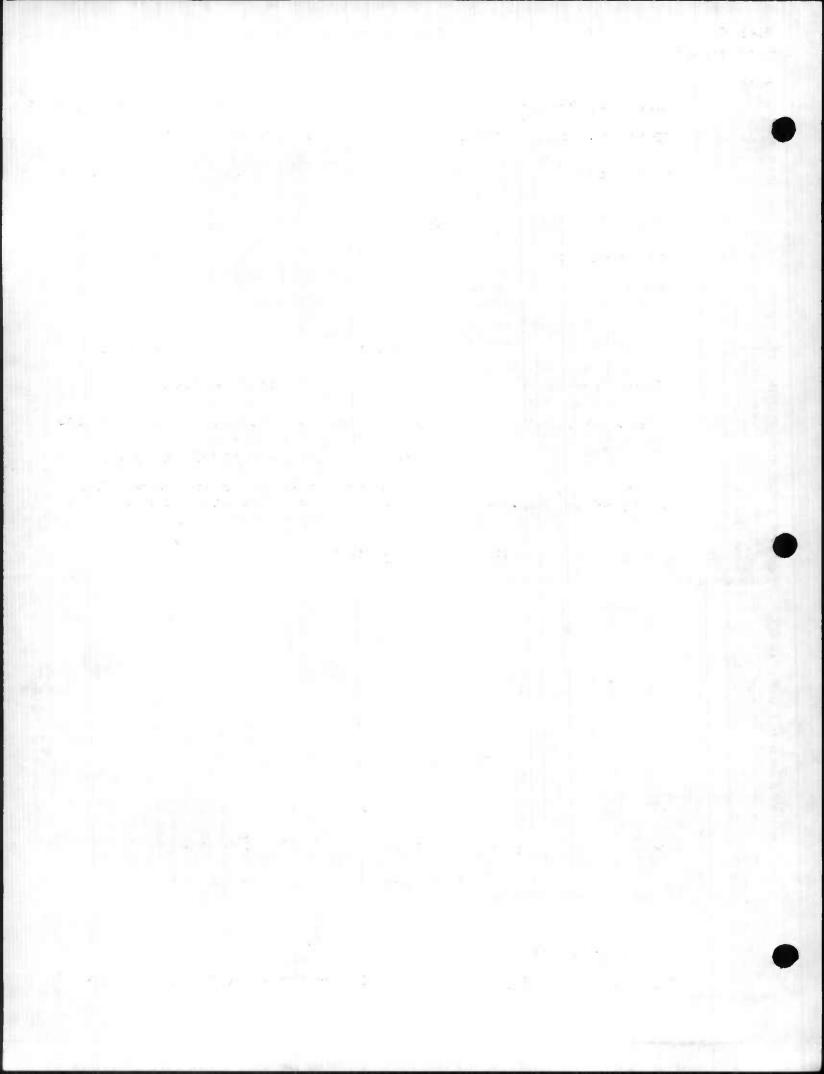
29d. Date signed (Month, Dey, Year) 29c. License number JUNE 20,1998 O.C.M.E

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

MAWA MAD A. KONSW WD 1.

111 Penn Street, Baltimore, Maryland 21201

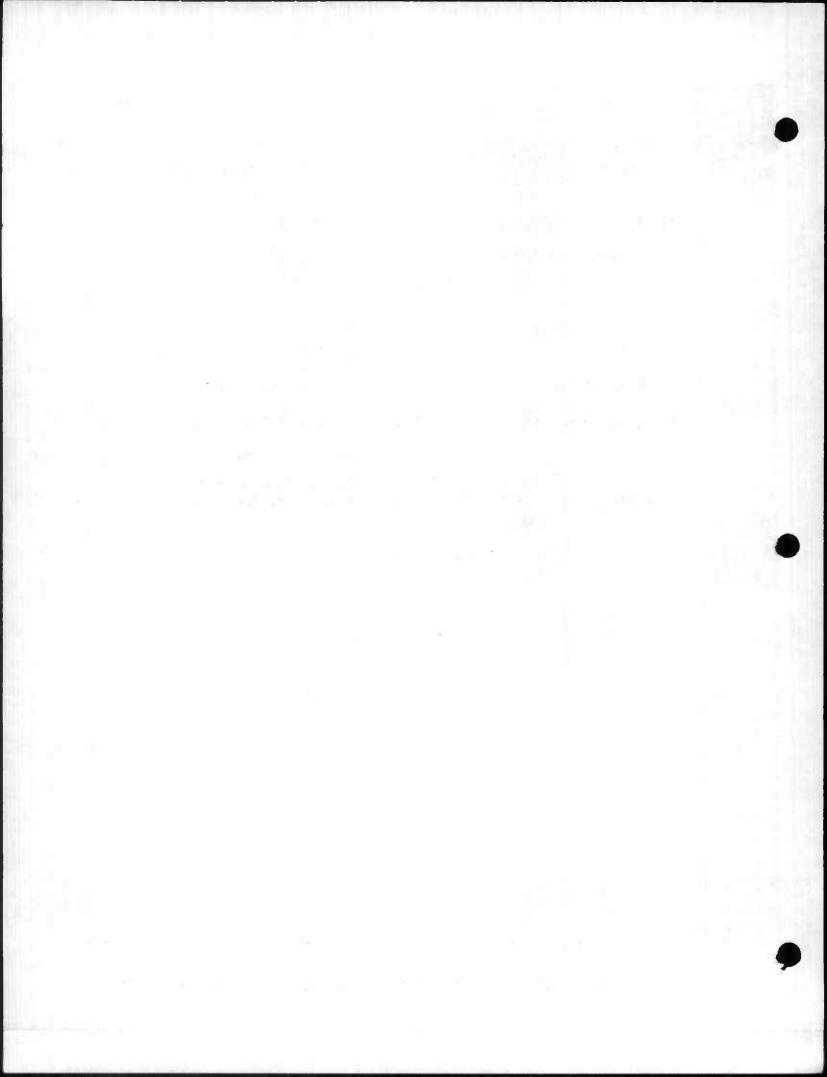
State Registrar



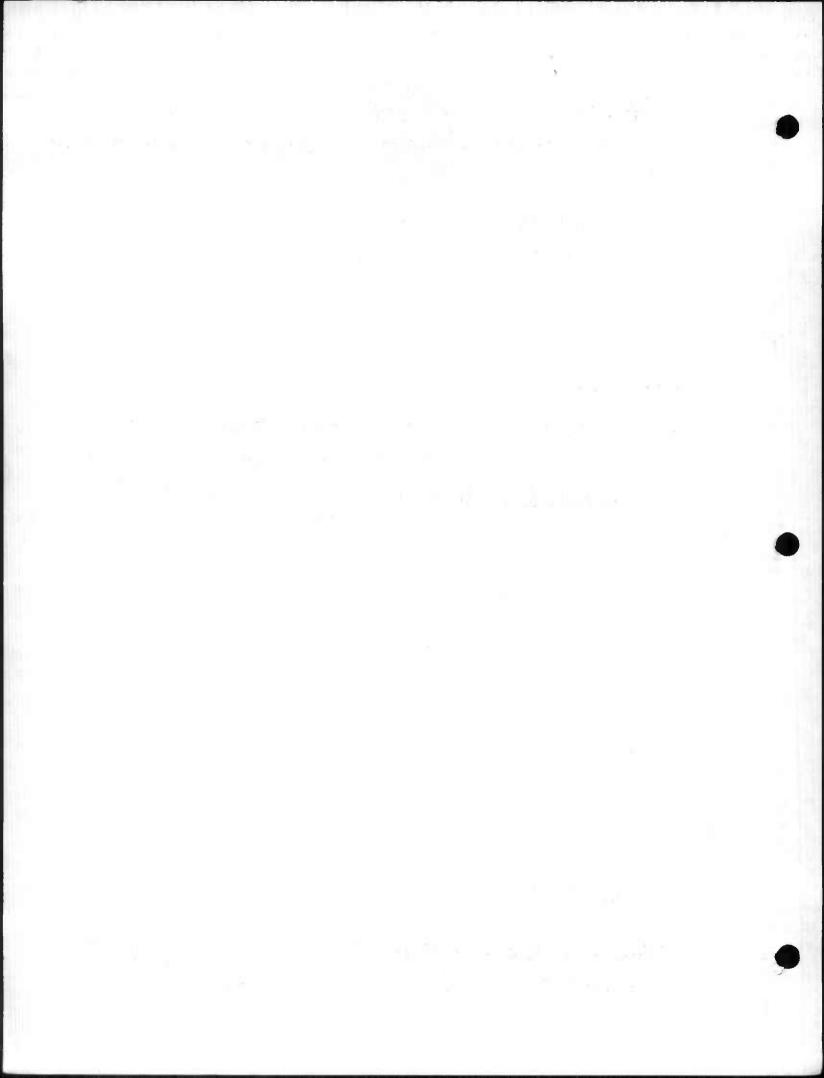
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death June 4. **Physician** 1998 17:09 GUY PASOUIRE DELUMEAU /Medicai 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington Months Deys Hours Min. August Lan Year 21 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funerai** 17€ M 2□ F New Jersey 153-16-8467 76 Yrs. Director Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Washington Hagerstown Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 13629 Donnybrook Drive 21742 USA permit. Pages 1 end 2 should be filed within 72 hours efter deeth v Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a any Injury or other treumatic svent, the Mexical Examples in that 1 once. Funeral 12. Wes Decedent Ever in U,S. Amed Forces? 1 Yes 2 No 194 If Yes, Give Year or Detes: 194 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Meritel Stetus 1942 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ White 1946 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Truck Manufacturer 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) Henri P. DeLumeau Louise Besnard 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Doris DeLumeau, Wife 13629 Donnybrook Drive, Hagerstown, Maryland 21742 20e. Method of Disposition

1 Description 2 Cremetlon 3 Removel from Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete Cedar Lawn Memorial Park June 8 Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Furieral Service Coensee ²² Name end Address of Facility
Douglas A. Fiery Funeral Home Oll. 1331 Eastern Blvd. N., Hagerstown, Maryland 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Malignant mesothelioma months Examiner Due to (or es e consequence of): Examiner requires thet the death certificate be asscuted physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) as for use signed by the e Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? page 2 s hes certificata 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was cese referred to medical exeminer? Be 28. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 █ DOA funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) within 24 hours after dea To the Funeral Director completaly filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Ccritifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es stated. 29a. Certifie Medicai (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. \$ 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 0 D21457 June 5, 1998 w 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Abdul Waheed, M.D. 12821 Oak Hill Avenue, Hagerstown, Maryland 32. Registrar's Signeture State Lulia Davidson-Randall Registrar



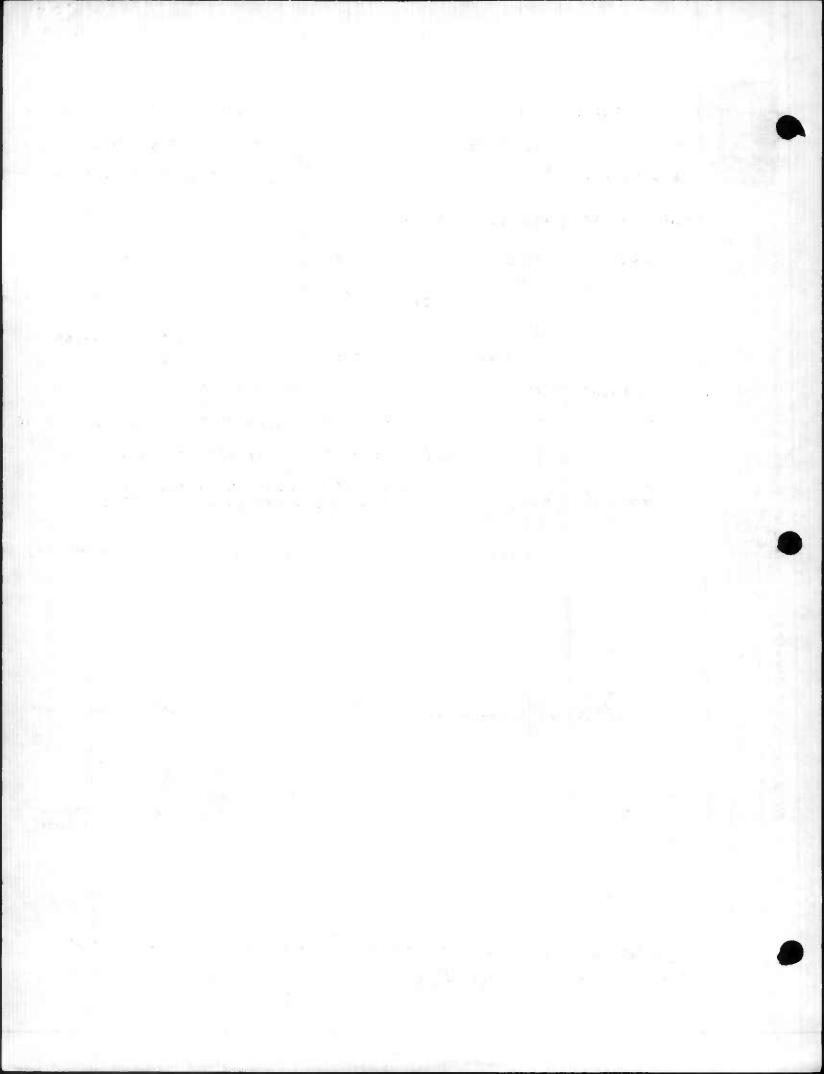
			State o	r marylan		epartment of F Certificate of		mental Hy	giene g	8	.1383			
			Decedent'a Name (First, Middle, Last)				7	2. Date of De	eth	Vaar	3. Time of Death			
	Physici /Medic		Helen	Dui	10	an		Month	13 C	7 S	0135			
)	Examir		4a. Fecility Name (If not institution, give street and nu				4b. City, Town, or	Location of Deat		of Death	0			
	c		Chesapeake He	belth	C	are	ANVE	16	April	Ar	und			
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. 77	lest birth Y	Months Devs	Hours Min.	8. Date of Bit (Month, Da 09/22/	th ay, Year) 1920	9. Birthple Count Penns	ace (Stete or Foreign ry) Sylvania			
П	pur *	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									d. Inaide City Limits			
	f sho	0	MD Anne Arundel								1 ☐ Yes 2 ⊋ No			
MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11g. Citizen of What of the Code 11											rv?			
	3e or	i Di	1151 Locust Tree Drive		USA									
20	iges 1 and 2 should be filed within 72 hours after death with the Manyland it of Health and Mental Hygiene. If itsm 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	Armed For 1 Never Married 2 Married 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes, Girl 1 Yes	2 XNo	S.	13. Was Decedent of H If Yes, specify Cube	dispanic Origin? (S en, Mexicen, Puerl Specify:	pecify Yea or No to Rican, etc.)	ecify Yea or No- Rican, etc.) 14. Race Bleck, Specify:					
0	tural tural	q pe	3 ☐ Widowed 4 ☐ Divorced Year or D 15. Decedent's Education	etes:	160 [ecedent's Usuai Occup	ation		16b. Kind of Bu					
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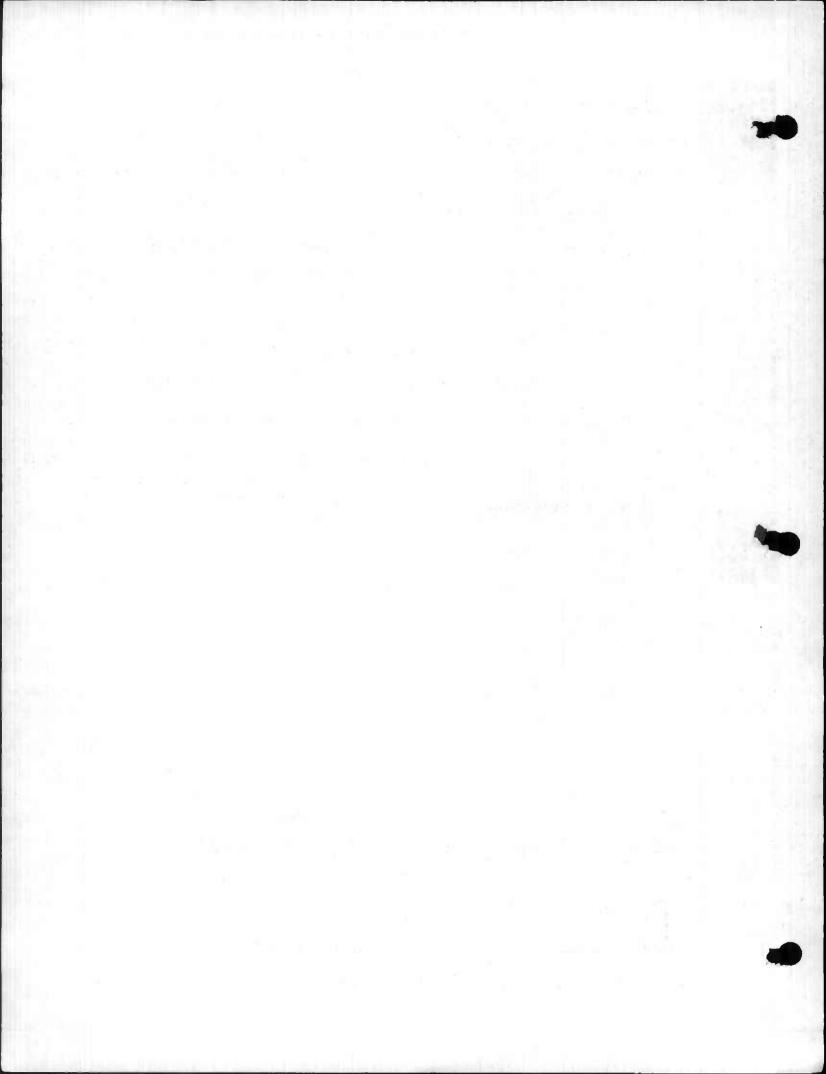


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Date of Death **Physician** 2 Dey Month VIRGINIA 1310 KUTH /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death SINOY SPRING 4c. County of Death Examiner montgom (R) BROOKE GROVE NURSING CONTOR If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Sacurity Number 9. Birthplaca (Stata or Foraign 8. Data of Birth (Month, Day, Year) Oct 12, 1913 6. Sax 7. Age (In yrs. last birthday) **Funeral** Days Blue Ridge Summit Hours 1 □ M 2 🖸 F Yrs 84 **Director** 218-03-1423 Usual Residance of Decedant the Marylend show 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avant, its filedical Examples. Montgomery MD Olney 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20832 USA Sparten RD Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 12. Was Decedant Evar in U,S. 14. Race - Amarican Indian, Armad Forcas? 1 ☐ Yas 2 XNo If Yas, Giva Black. Whita, atc 1 Never Merriad 2 Merried Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yas 2 📉 No Specify: þ f Yas, Giva Yaar or Datas: 3 X Widowed 4 □ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Federal Government Engineering 17. Fether's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Meiden Sumema) Charles C. Tracey Etta Key Boyer 19e. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Coda) Germantown MD 20324 Sandsfield Terr 20876 Judy A. Kaminsky 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 1 KBuriel 2 Cramation 3 K Ramovai from Steta 6/27 4 □ Donation 5 □ Othar (Specify) Waynesboro PA 17268 Green Hill Cemetery 21. Signatora of Funerel Service Licensee 22. Nama and Addrass of Facility Grove Funeral Home, 23a. Parti. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List *only one* cause on each line. 50 S Broad ST Waynesboro PA 17268 Approximata Intarval Batween Onsat end Death Physician PNEUMONIA /Medical Immediate Cause (Finel disaasa or condition resulting in daath) Examiner Dua to (or as e consequance of) Examine RT. HIP physicien and the buriel-transit Sequentially list conditions, if eny, laading to Immadiata causa. Entar Undarlying Ceusa (Disaasa or Injury Dua to (or as a consaguance of): Box 68760. certificate be Physician/Medical that initiated avants rasulting in daeth) Last Due to (or as a consequence of) 89 950 Por P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown signed by Division of Vital Records. by 2 Completed 24a. Wes an eutopsy 24b. Wara autopsy findings peed availabla prior to complation of cause of deeth? has 1 ☐ Yas 3 No 25. Was casa referred to medical examplear? Be 26. Placa of Deeth (Check only one) examinar? 1 2 Yas 2 □ No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) To this funeral 27. Mannar of Death 28d. Dascribe how injury occurred to FLYCRUMO TRUPOSO AT HOUSE AND FLYCRUMO GREATER OF RT. HID 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury et Work? Certification: After Attending 1 Neturel 5 Panding death. ABRIL 30, 1999 invastigation 8:00 PM 1 ☐ Yas 2 No i or Attendi after death. Director: A Accident the 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 6 ☐ Could not be 3 Suicida 28a. Piaca of Injury - At home, farm, straat, factory, offica building, etc. (Spacify) 4 Homicida ROCKUVUE, MO 24 hours a Funeral edical 29a. Certifier 1 Certifying Phyeician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 015236 DMA M.C 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) PIKE, ROCKVILLE, MO 20852 I MARGOUS

32. Registers Signature Julia Daydson-Randell

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1 Decedent's Neme (First Middle Last) 2. Date of Deeth FRECON HEATHER 98 ine 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) BATIMORE OF MARYLAUD I LOSPITAL BACTLUORE S ex 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) UNIVERSITY 5. Social Security Number 7. Age (In yrs. lest birthday) 29 Yrs. 6 Sex Birthplace (State or Foreign Country) 1□ M 2□ F Months Days Hours Yrs. PA 210-64-0122 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1738 Heather Lane 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20% Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Gary L. Johnson Beth A. Hied 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Benjamin R. Frecon 1738 Heather Lane, Frederick, Maryland Husband 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 6-23-1998 Chambersburg, PA. 17201 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas L. Geisel Funeral Home 333 FAlling Spring Road, Chambersburg, PA. 17201 23a. Parti-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACUTE RESPIRATURY DISTRESS SYNDROME Immediate Cause (Finel disease or condition resulting in death) TOXIC SHOUL SYNDROME - POST Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or trijury that initieted events resulting in death) Last UTERINE NECROSIS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 15 No 3 Probably 4 Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy parformed? ISCHEMIC NECROSIS - BOTH LEGS, AND HANDS 2 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 1 Naturel 2 Accident

and -transit certificate be execu physician ar s the burial-t P.O. Box 68760. USB Division of Vital Records, certificate has b

Examiner Physician/Medical à 10 Certification:

Physician

/Medical

Examiner

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Director

than "natural", or items 23s or the Medical Examiner must be a

nemit. Pages 1 and 2 should be filed within 2 spartment of Hestin and Mental Hyglene. reportant: If item 27 is marked other than "s my Injury or other traumatic event, the Med

Physician

/Medical

Examiner

altimore, Maryland 21215-0020

funerai After or Attanding after death. Director: Aft To the Hospital or Attal within 24 hours after dea To the Funeral Director completely filled in by the

25. Wes case referred to medical examiner?

5 Pending investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

UNIVERSITY OF MARYLAND

28f. Location (Street end Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

3 Suicide

4 Homicide

(Check only one)

29a. Certifier

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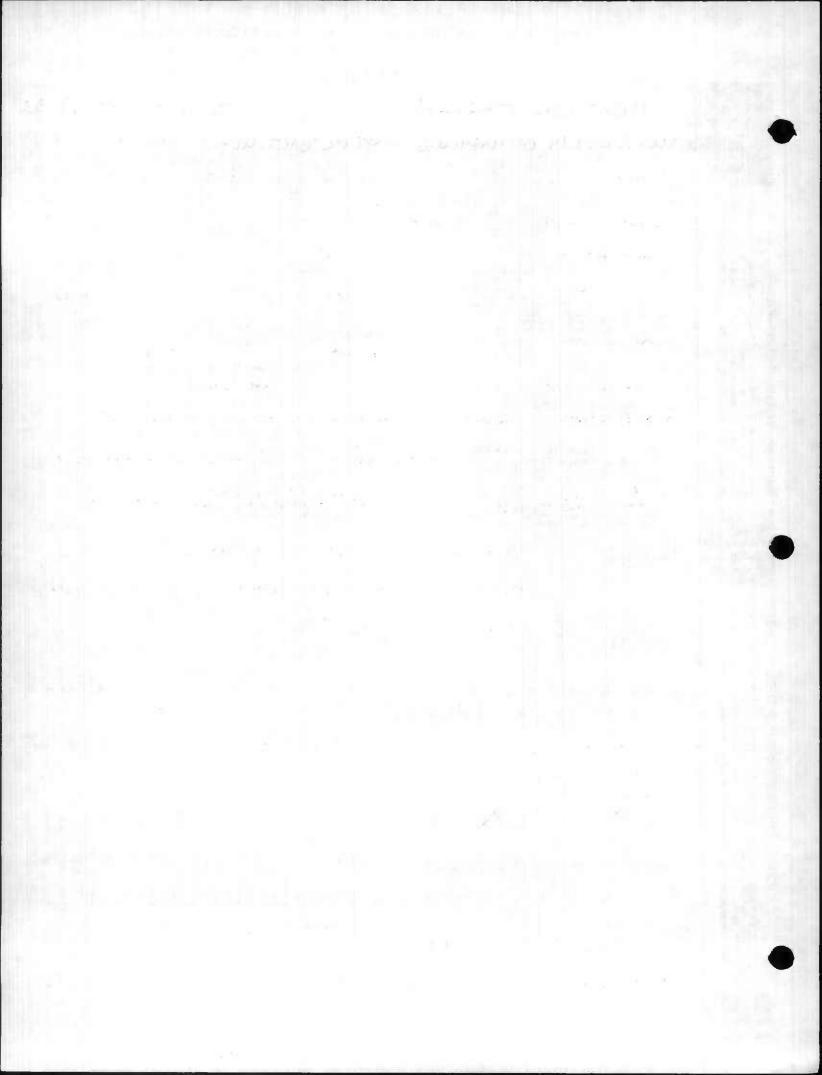
unrenus

29c. License number D46365 29d. Date signed (Month, Dey, Year) 6-18-98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MOURE, MD

32. Registrar's Signature who Davidson-Randose

Registrar



Pages 1, 2, 3 should

permit.

burial-transit

COMPL

BE 0 4 Homicide

1 CEF

29a. CERTIFIER

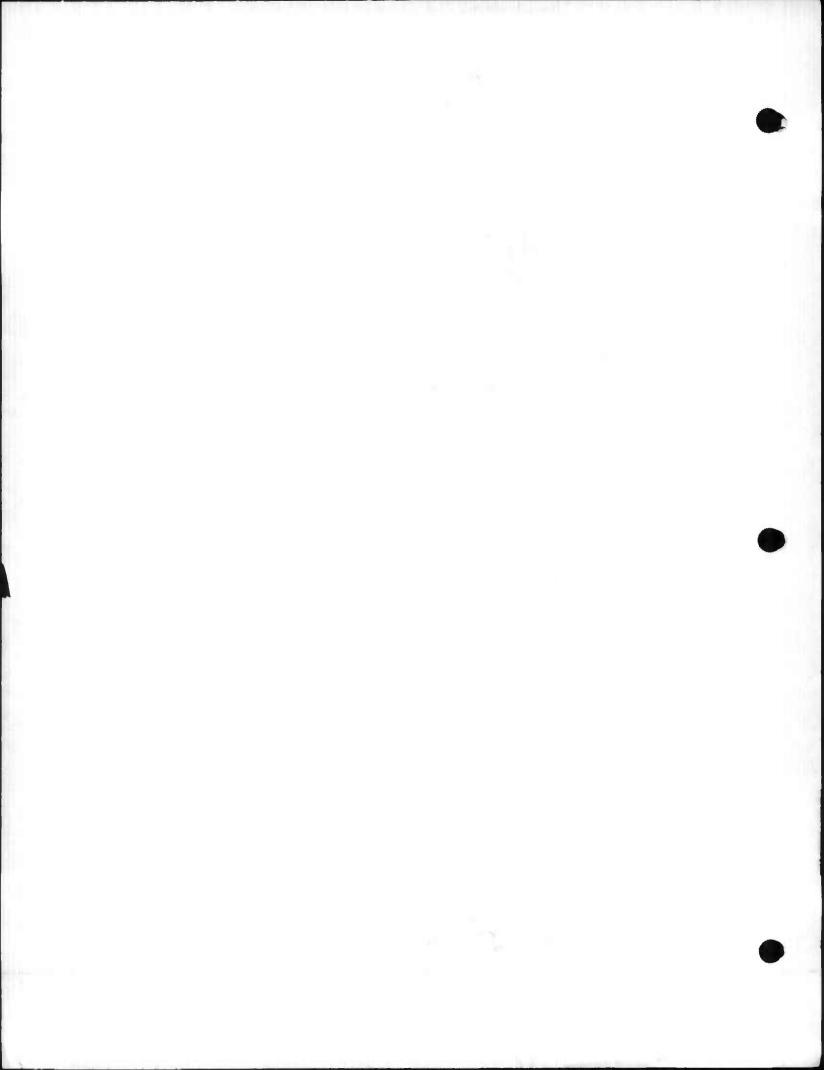
determined

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dent, of Health and Mental Hybiene prior to burial, cremation, or removal.	
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98 21388 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 6:15A Helen Louise French June 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign March 17,1932 218-30-9581 66 HOURS 1 M 2 X F YRS. MD 9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 11540 Ernstville Rd. DIRECTOR Big Pool, Washington RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Washington Williamsport 1 XXES 2 NO 10s. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3 West Potomac St. 21795 U.S.A. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married 1 - YES 2 - 10 Specify: Specify: white BY 3 ₩Idowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done life. Do NOT use retired.) gas station Elementary/Secondary (0-12) College (1-4 or 5+) COMPL attendent 10th grade 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Samuel Jacob Shirley Sr. Elsie Izora Pierce BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Anna Summers 11540 Erntsville Rd. Big Pool, MD 21711 20s. METHOD OF DISPOSITION

1 Disposition | 1 Removal from State | 1 Donation | 5 | Other (Specify) | 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Greenlawn Park June 5, 1998 Williamsport, MD 21. SIGNATURE OF FUNERAL SERVICE OCCURS 22. NAME AND ADDRESS OF FACILITY Sell Thompson Funeral Home, Inc. O.BOx 310 Clear Spring, MD ons that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or he interval Betw IMMEDIATE CAUSE (Fine) Onset and Death disease or condition Croces rimo ~ reaulting in death) month DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): . Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY 1 TYES 2 CHING 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural М 1 YES 2 NO BY Investigation 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 6 Could not be

	To the best of my knowledge, death occurred at the n the beals of examination and/or investigation, in my		
29b. SIGNATURE AND TITLE OF CERTIFIER	M	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO CO	MPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1110 Wedze	d Compus Rel	Hegerstown had
31. DATE FILEO (MOTET) PRI JON 1 1998	32. REGISTRAP'S SIGNATURE Pandell		V



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year STANLEY PAUL FOGLE 0404 June 27, 1998 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foraign Country) 8. Date of Birth (Month, Day, Year) 1XM 2□ F Months Days Hours Min. 167-07-4347 84 January 14,1914 Pennsylvania Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ◯ No Maryland Wicomico Salisbury 10e. Streat and Number 10f. Zip Coda 10g. Citizen of What Country? 21801 9139 Springhill Lane USA 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, atc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowad 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Circulation 10 Newspaper 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middla, Last) William Fogle Swain Mary 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edith Clair Fogle/Wife 9139 Springhill Lane, Salisbury, MD 21801 20b. Place of Disposition (Nema of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory Gardens 6/29/98 Hebron, MD 4 Donation 5 Othar (Spegify) 21. Signature of Funeral Service Vicenses 22. Name and Addrass of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 Sath. Do not enter the mode of dying, such as cerdiac or respiratory arrast, Appr 23a. Part1. Enter the dilease, or complications that used shock, or heart feilure. List only one cause on each lin Approximate Intervel Between Onset end Death Immediate Ceuse (Finel 1) i real) diseasa or condition resulting in death) Due to (or as e consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Causa (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes en eutopsy 1 ☐ Yes € No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medice 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 Yes 2€ No 1 Inpatient 2 PER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 DNatural 5 Pending Injury 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) 3 Suicide 4 Homicide

physician and s the burial-transit certificate be executed Box 68760 88 950 ò P.O. detached signed by the paga 2 s has Division of Vital Attending Physician: director this funeral After after death. Director: Aft 6 To the Hospital of within 24 hours a To the Funeral D

Physician/Medical þ Completed Be 10 Certification:

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7 is marked other than "natural", or frams 23s or 25s-f shot trsumstic event, the Modical Examiner must be notified at

1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 is marked other then "natural", or frems 23

permit. Pages 1 at Department of Heat important: if flem 27 any Injury

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Examiner

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29a. Certifier (Check only one) 29b. Signature and title of certifian

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

SHORE Dr.

29c. Licensa number

29d. Date signed (Month, Day, Year)

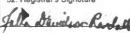
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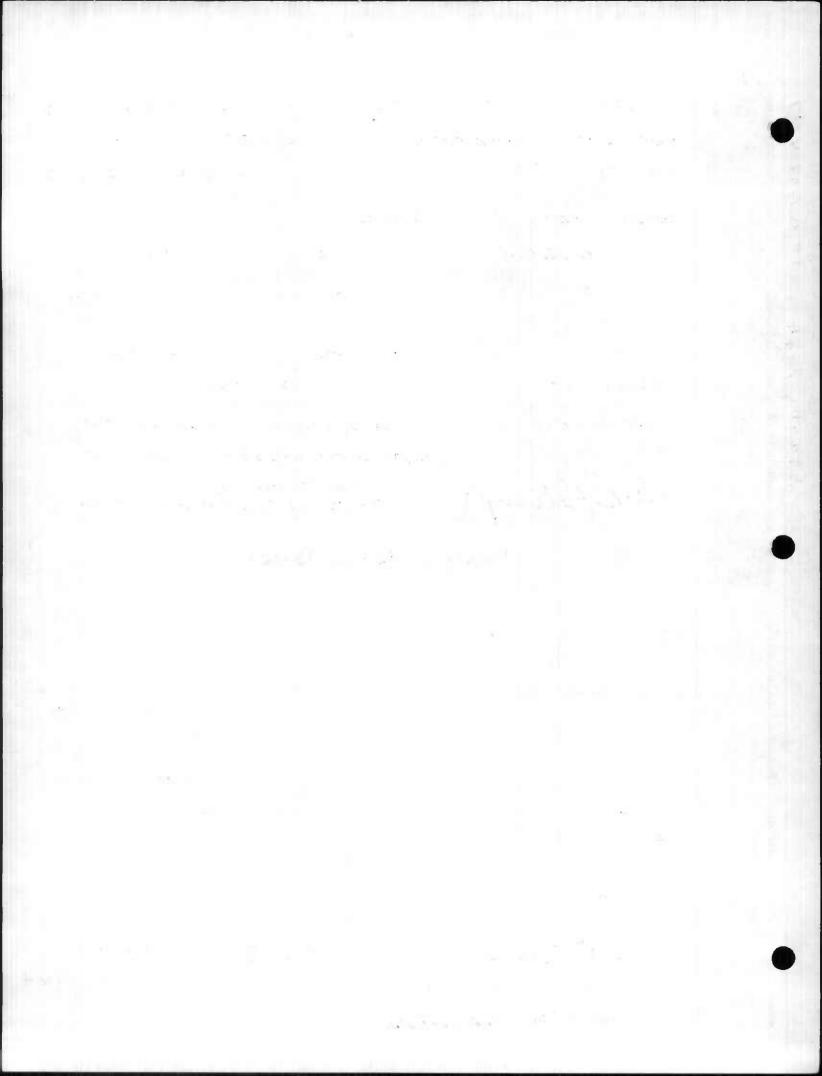
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) m.o.

HEARNE 31. Date tiled (Month, Dey, Year)

EASTERN 32. Registrar's Signeture

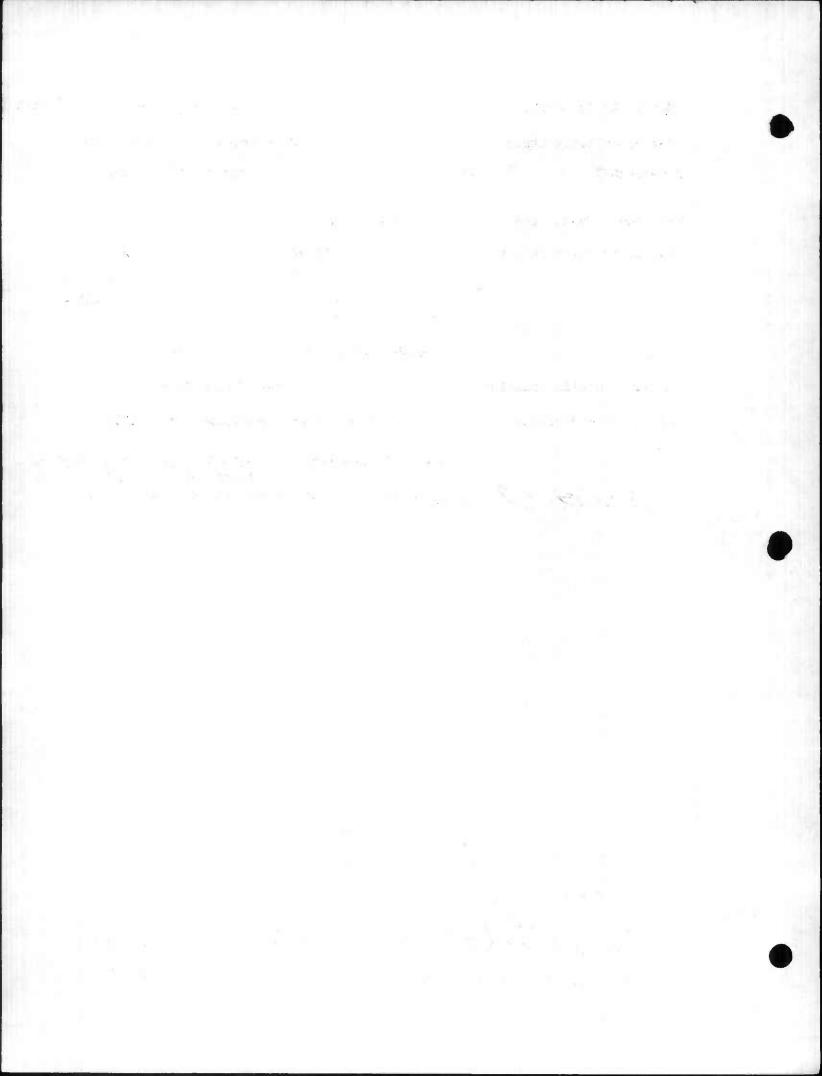
JUN 30 1998





State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month 00:00 hrs Myrtle Louise GROVE 24, 1998 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 237 N. Mulberry Street Hagerstown Washington Months Deys Hours Min. 8. Date of Birth (Month, Day, Year) Nov. 1, 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Yrs. 216-22-2057 72 Director Maryland Usuel Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 237 N. Mulberry Street 21740 USA Funeral permit. Peges 1 and 2 should be filed within 72 hours after deet Department of Heelth end Mentel Hygiene. Important: If item 27 is marked other than "natural: Any Injury or other traumatic averages." 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yee or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 1 Yes 2X No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: à Specify: white 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cashier/housewife dairy 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Harvey Franklin Crampton Grace Viola Boyer 19e. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Kinna - daughter 211 Carroll Court, Boonsboro, Md. 21713 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1X Buriei 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 6-27-98 Hagerstown, Maryland 21. Signature of Funeral-Service Licensee 22. Neme end Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that ceused the death. Do meter the mode of dying, such as cardlec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Betwee Onsef and Deel **Physician** al carcinoma /Medical immediate Cause (Finel diseese or condition resulting in deeth) **Examiner** Examiner physician and s the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): signed by the at d be detached for Part il. Other elanificant conditione contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use centribute to the cause of death? 21 No 1 | Yes 3 Probably 4 Unknown à 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed Deen completion of cause of death? has certificata 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: 24 hours efter death. Funeral Director: After this certifica funeral director, 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Desidence 8 Other (Specify) 2 1 🗆 inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28a. Dete of injury (Month, Day Year) 28c. injury at Work? 1 Detural 5 Pending investigation 2 🗆 No 1 Yes 2 Accident To the Hospital or Atter within 24 hours efter dee To the Funeral Director completely filled in by th 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, farm, streef, factory, office building, etc. (Specify) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end-manner stated. edicai 29e. Cartifler 29d. Dete signed (Month/ Dey, Year) 29b, Signature and title of certifier stomac 32. Registrar's Signature State wha Davidson-Registrar

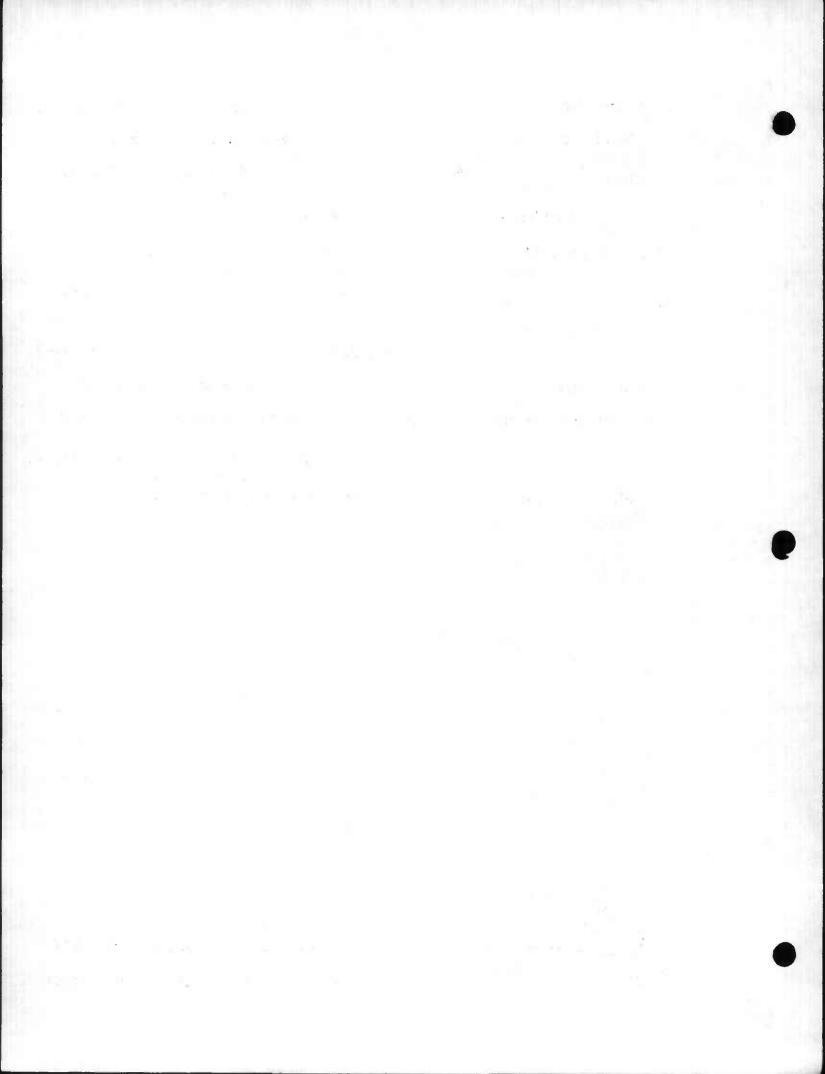


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth Month **Physician** Anita June GREER /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 320 Devonshire Road Hagerstown Washington Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) Sept. 20, 1931 5. Sociel Security Number 7. Aga (In vrs. last birthdev) 9. Birthplace (State or Foreign Funeral 1 □ M 2 □ X F Months Yes Unknown 66 Wash.D.C. Director Usual Rasidence of Decedant the Maryland 10a. Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at Director Washington Hagerstown Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours effer deeth with a Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 2000s. 21740 USA 320 Devonshire Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No tf Yas, Giva Yaar or Datas: 11 Maritai Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married white 1 ☐ Yas 2 ☑ No Specify: by 3 ☑ Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation 16b Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT usa ratired) Elemantary/Secondary (0-12) Collega (1-4or 5+) homemaker her own home 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Mary Katherine Ritenour Lloyd C. Berger 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 997 Kings Landing Rd., Hampstead, N. C. 28443 William Berger - brother 20b. Place of Disposition (Name of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burlal 2 □ Cramation 3 □ Ramoval from Stata 6-27-98 4 ☐ Donation 5 ☐ Othar (Specify) Hagerstown, Maryland Rest Haven Cemetery 21. Signetura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 red In estal 23s. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory strest, shock, or heart failure. List only one cause on each line. Approximeta Intarvsi Between Onset end Deeth Physician Immediata Causa (Final diseese or condition rasulting in daath) /Medical ARTERIOSCLEROTIC CARDIOVASCULAR OLSBASK Examiner Due to (or es a consequance of): Physician/Medicai Examiner DECADE C DIABBTES MELLI TUS attending physician end for use as the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disaase or Injury Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, that initiated evants resulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. ed by the a 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Whiknown SCH120 PHRENIA þ 24b. Wara autopsy findings svallable prior to completion of cause of death? 24a. Wss an autopsy performed? Completed OVON COMPLIANCE certificate hes b lirector, page 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Wes casa rafarred to medical examiner?

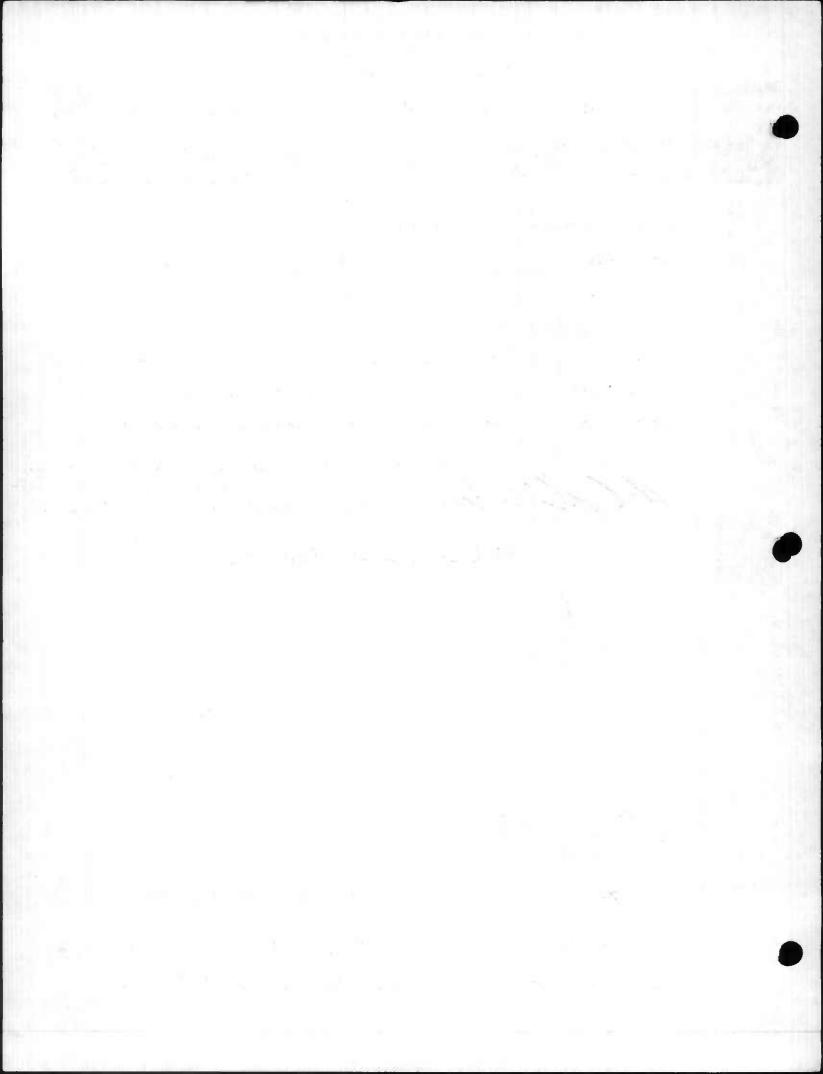
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Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data end piece, and due to the cause(s) and mannar stated. 29e. Certifian within 24 hor To the Fune completely fi (Check only one) 29b. Signatur 29c. Licansa number 29d. Data signed (Month, Day, Year) md-little of contiller 040622 JUNU 25, 1998 mp 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) 19236 MERROW VIEW OR HABERSTOWN MR UZI CAMAS MP EXN 659 31. Date flied (Month, Day, Year) 32. Registrer's Signature State JUN 29 1998 Julia Davidson-Randelle Registrar



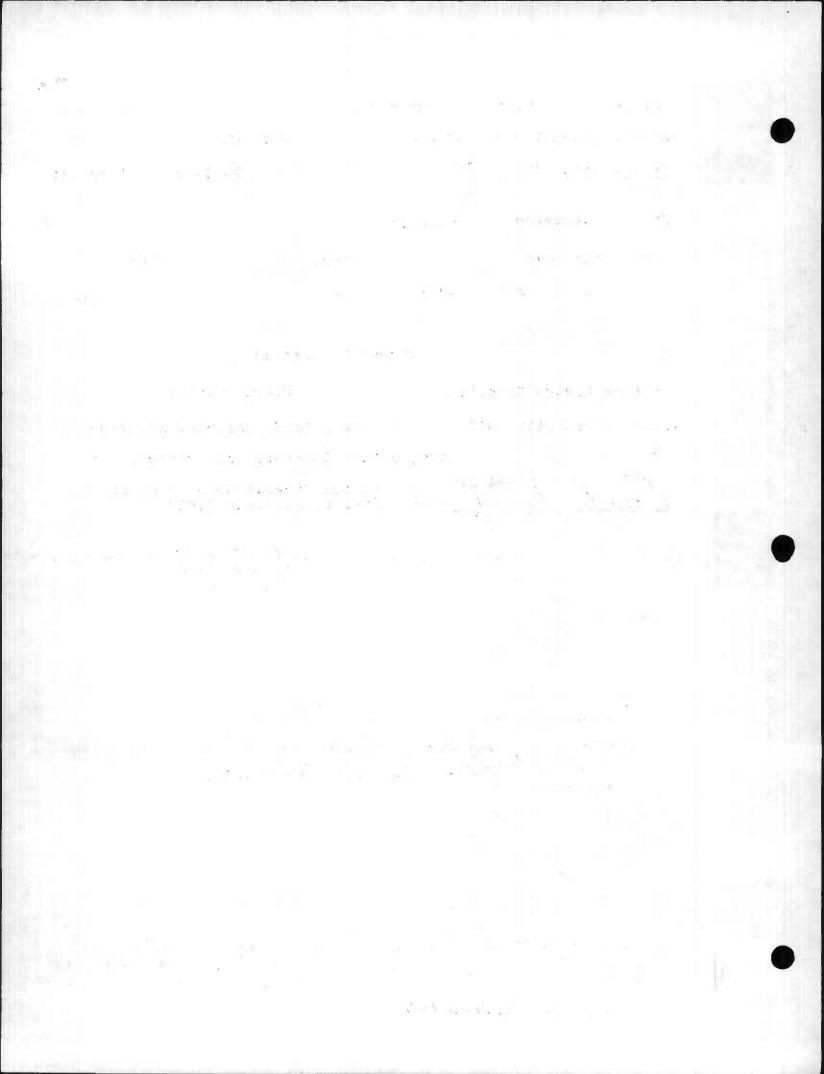
State of Maryland / Department of Health and Mental Hygiene

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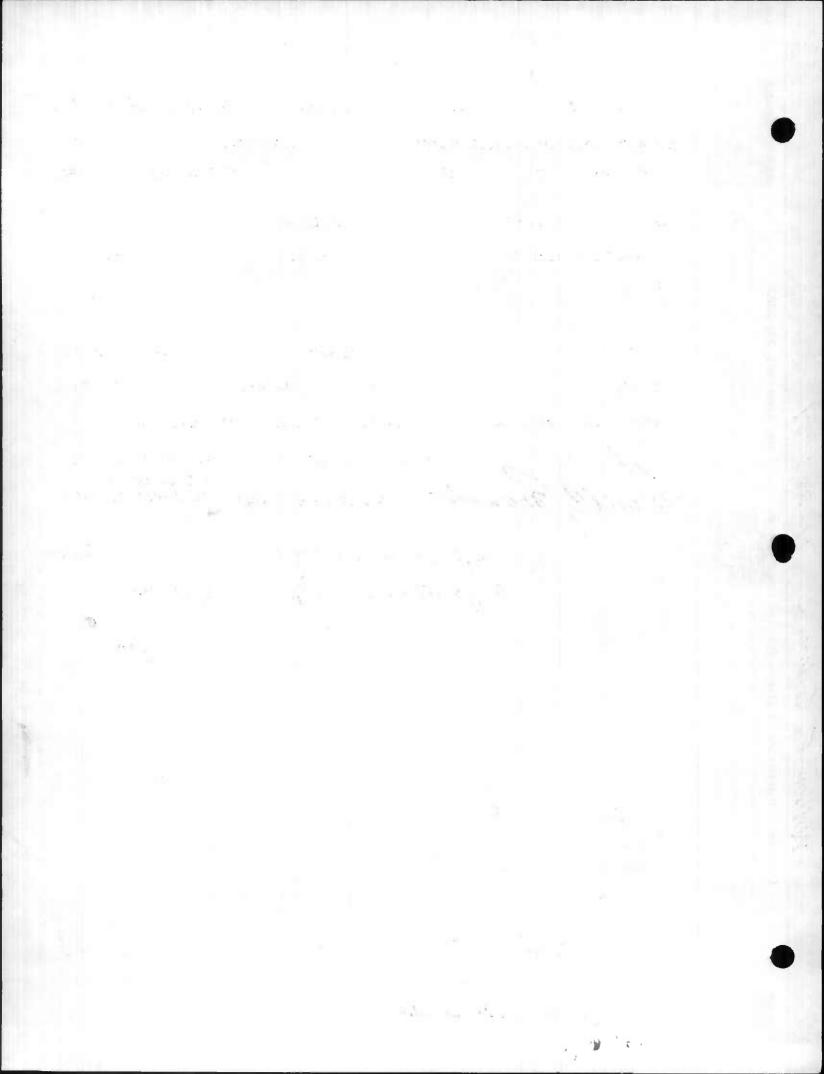
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Baltimore,	Pages 1 lent of H nt: If iter ry or ott		20a, Method of Disposition 1 Burlel 2 □ Cremation 3 □	Removal from St	cen	netery, cren	sition (Neme of netory or other pla		Date	20c. Location			
Ein.	permit. Pa Departmen Important: any injury		4 Donation 5 Other (Specify		Mar	1		emetery	//1	Marde1	La, M	d	
Ba	permit. P Departmol Importan any injur		21. Signature of Funeral Service Linear MOO-417 Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814										
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	lications that on	and the death.	Do not ente	er the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Intervel Between	
	Physician /Medical		Immediate Cause (Finel disease or condition resulting in deeth) Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of):										
	Examiner	*	resulting in deeth)		Due to (or e	e conseq	uence of):	120	reas	2	/		9
	outed id ansit	Examiner	Sequentially list conditions	b	Due to (or e	s a conseq	uence of):				- 1		_
ő,	sete be executed shysicien and the buriel-transit	EX	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury		,		1						
8760,	shys the	dical	that initiated events resulting in deeth) Last	G	Due to (or a	is e consequ	uence of):						
Box (ettending p	Me		d							1		1
B	death certifix e ettending p ed for use as	cla	Part II. Other significant conditions co	ntributino to deal	th but not result	ing in the ur	nderiving cause gi	ven in Pert I.	23b. Did	tobeceo use	contribute to	the cause of death?	?
P.0	by th	Physician/M	N			12	1	20,	/	Yes 2 No			
	es the	à	peur		2	101.	pua	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	71		T		
0.00	been sign	eted	Corona	ung a	rtes	V	Rese	are.	24a. Was perfo	an autopsy ormed?	av	ere autopsy findings ailable prior to mpletion of ceuse	
Records,	hes hes	Completed	90	AB.	2_	45	nol	Film	letro	Yas 21 No		death? ∃Yes 2□No	
Vital	delan: The	Be	25. Was cese referred to fiedical	1 -		/ / /	0//	26. Plece of De	eth (Check only	one)			_
of V	5 00 0	၉	1 Yes 2 HNO			R/Outpatien	I SLI DOA		lome 5 ☐ Resi			y)	
ou o	ding Ph h. After th funeral		27. Menner of Deeth 1. □ Natural 5 □ Pending	28e. Date of (Month,	Injury 2 Dey Yeer) 2	8b. Time of Injury	28c. Inju Wo M 1	ryet rk? IYes 2 □ No	28d. Describe	how injury occ	curred		
Division	Attending r death. ector: After by the fune	Cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place o	f Injury - At hom	ne farm str	eet, factory, office	1105 2 110	28f, Location (Street end Nu	mber or Rure	I Route Number,	
Θį	s effer it Direction by	Certification:	4 Homicide	building	, etc. (Specify)	,,			City or To	wn, Stete)			
	To the Hospital or Attend within 24 hours effer deatl To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam		is of examinetio								-
	To the To the comp	ž	29b. Signature and Title of certifier	1 1	2 ,		29c. Licen	se number		29d. Date sig	ned (Month,	Day, Year	
	1		Long	-gal)	1/5	767	0	6/	28/3	28	
	4		30. Name and address of person who	emploted cause	of death (Item 2	a) (Type	Print 10	Elish	uer	Fli	ff ut	2180	7
	Stat Registra		31. Dete filed (Month, Dey, Year) JUN 3 0 1998	Jalan Salan	nistrar's Signat	odall.			(1			



State of Maryland / Department of Health and Mental Hygiene

		C	ertificate of l	Death	Re	g. No.	21394					
	Decedent's Name (First, Middle, Last)				2. Dete of Death Month	Day	3. Time of Death					
Physician /Medical	WILLIAM	F.	GILMO	ORE	June	24 19	98 1715					
Examiner	4a Facility Name (If not institution, give street end number)		4	b. City, Town, or Lo		4c. County o	Death					
	PENINSULA REGIONAL MEDICAL	CENTER		SALISB	IIRV	L	ICOMICO					
Funeral	5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Dey,		Birthplace (State or Fore Country)					
Director	142-28-5764 1፟፟፟M 2□F	63 Yrs	Months Deys	Hours Min.	MARCH 6,		NEW JERSEY					
	Usual Residence of Decedent											
Hygiene. ther than "natural", or items 23a or 28a-f ahow int, the Medical Exercitive must be notified at the Completed by Funeral Director	10a. Slate 10b. County	10c. City, Town or	r Location				10d. Inside City Lim					
28e-f sho notified at	MD WICOMICO		SAL	ISBURY			1 ☐ Yes 2 💢					
be notified Director	10e. Street and Number	1	10f. Zip Code		10	g. Citizen of W	nat Country?					
a die	114 E. WILLIAM ST.		2.	1801		11	.S.A.					
r Rome 23a dree rount Funeral	11. Marital Status 12. Was Decedent	Ever in U,S.	13. Was Decedent of H		city Yes or No-	14. Race	- American Indian,					
E E	Armed Forces? 1 Never Married 2 Married 1 Yes, 2 M If Yes, Give	No	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		Ricen, etc.)	Black	, White, elc.					
by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🕅 No	Specify:		Specify:	WHITE					
P	15. Decedent's Education	16a. De	ecedent's Usual Occup	allon	1	6b. Kind of Bus	iness/Industry					
To Be Complet	(Specify only highest grede completed)	(G	ive kind of work done of e. DO NOT use retired	du <i>ri</i> ng most of workli d)	ng							
Be Completed	Elementary/Secondary (0-12) College (1-4or	5+)	LABOR			CERAMIC	S FACTORY					
Ö	17. Father's Neme (First, Middle, Last)		Di DO	18. Mother's Name								
ä	LYMAN D.	CT	LMORE	ELIZABI	TH		GEDDES					
10	19e. Informent's Name/Reletionship (Type, Print)		lailing Address (Street			City or Town						
	ROBERT SMITH - PER. REP.											
		_	14 E. WILL] isposition (Neme of	LAM ST.	SALISBU		Z18U1 City or Town, State					
	20a. Method of Disposition 1 □ Burlal 2 X Cremation 3 □ Removel from State	cometen	cremetory or other plea	(e)	Date	oc. Location - C	ny or Town, State					
	4 □ DonaHop 5 □ Other (Specify)	CAMBRID	GE CREMATO	RY 6	-25-98	CAMBR1	DGE, MD					
	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility 705 E. MAIN ST.											
	BOUNDS FUNERAL HOME SALISBURY, MD 21804											
1	23a. Part1. Enter the disease or complications that ceuse	d the death. Do not			14-0		Approximate interval Between					
	shock, or heart feilure. List only one ceuse on each I	ne.					Onset and Death					
n il	immediate Cause (Final	1	1. 1.0-	in t			2 Wes					
r	disease or condition resulting in deeth) a.	prococu	al Men	ngruo.			DWKE.					
5		Due to (or es a cor	rsequence of):	del		1						
Examiner	b. acq	wered 4	inmune!	aficien	ly lys	april	i					
xar	Sequentially list conditions, if eny, leading to immediate	Due to (or as a con	sequence of):	U								
	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury c.											
edical	that initiated events resulting in death) Lest	Due to (or as a con	sequence of):									
2	d											
Medical Certification: To Be Completed by Physician/	<u> </u>											
Sic	Part II. Other significant conditions contributing to death b	out not resulting In th	e underlying ceuse giv	en in Part I.	23b. Did tob	oacco use con	tribute to the cause of dea					
Phy					1 □ Ye	8 2 No	3 Probably 4 Unkn					
by												
P					24e. Was an	eutopsy	24b. Were autopsy finding available prior to					
Set							completion of ceuse of death?					
E					t □ Ye	s 2KINO	1 ☐ Yes 2 ☐ No					
Ö	25. Was case referred to medical			OS Plans of Dooth		/-						
ä	examiner? / Hospital: V	-5	Oth	26. Plece of Deeth			42753.1					
1	I Tes 20 No Inpati		itient 3L DOA	4 U Nursing Ho	me 5 Resider							
o	1 Naturel 5 ☐ Pending (Month, De	y Year) Inju	ry Wor		EOO. Describe no	w mjury cocurre						
cat	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □ No	20(1		and Courts Name has					
E	determined 200. Flace of In	jury - At home, farm c. <i>(Specify)</i>	, street, factory, office	1	City or Town,	Stete)	or or Rurel Route Number,					
Ce												
cai	29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch	of my knowledge, d	eath occurred at the time	ne, date and plece, a	and due to the ca	use(s) end mei	nner as stated.					
B	one) and menner st	ated.										
Σ	29b. Signeture end title of certifier		29c. Licens	e number	29	d. Date signed	(Month, Day, Year)					
	C Homm	ms	1)2	5219		6-	25-78					
	30. Neme end address of person who completed cause of	deeth (Item 23e) (Ty	pe, Print)	- /								
	Charles steaman, m.o.	30434	MT VERN	ON RD.	Prince	ss Ann	e mo					
ate	C	rar's Signature										
rar	JUN 26 1998	rar's Signature volum Rawlett										
	3014 20 1330											

William F. Gilmore

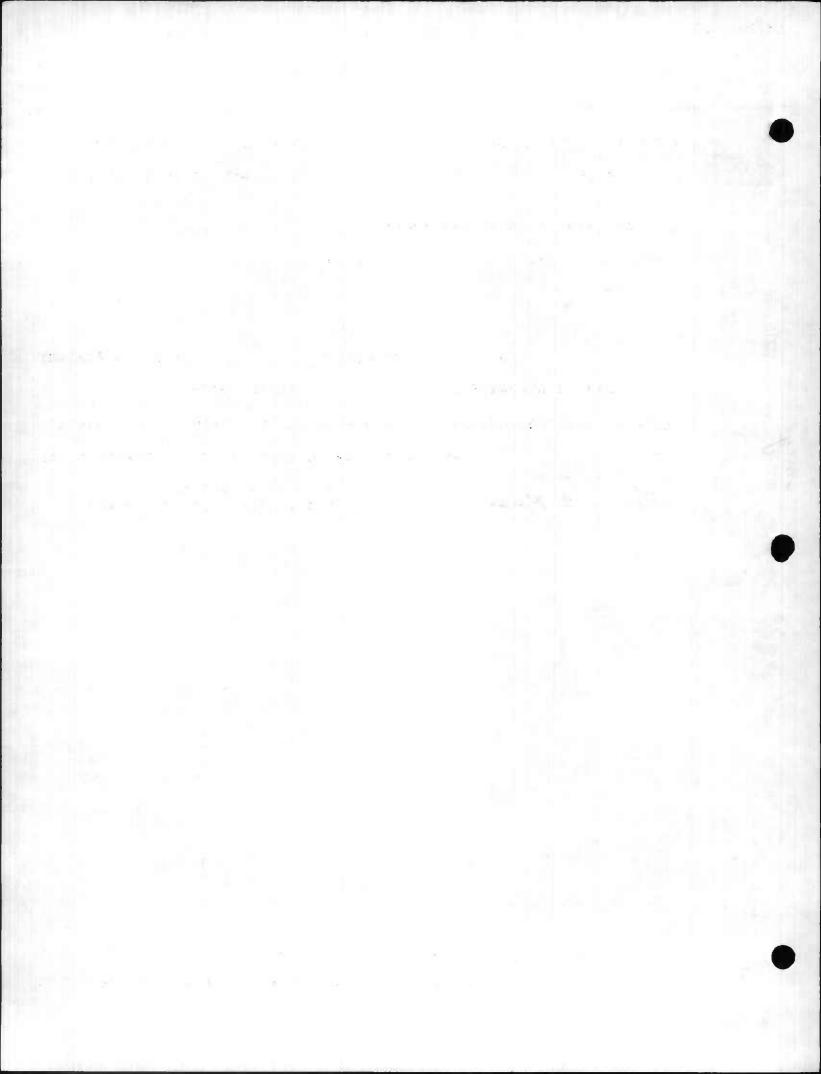


98-3869-003

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **AGNES** 7-14 Certificate of Death GALLOWAY ITEMS: #23 PART 1, 27 PER MEO FILM G-761 Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** AGNES GALLOWAY 06, 1998 JULY 8:05A.M. /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys 1□M 2√DF Months Hours Director 212-42-9490 NOV. 7 1944 MARYLAND Usual Residenca of Deceden 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits show the Maryle r than "natural", or items 23s or 28s-f shorth Medical Examiner must be notified at XXYes 2 No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1828 BOWMAN DRIVE Funeral 21401 US 14. Race - American Indien, 11. Maritat Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: BLACK aitimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. ther than Elementary/Secondary (0-12) College (1-4or 5+) 12th CUSTODIAN US NAVAL ACADEMY 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be Montal ELIJAH GALLOWAY SR. ALENE BROWN Thand ? 19e. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health reportant: If item 27 i TANJALA BROWN (DAUGHTER) 1828 BOWMAN DRIVE ANNAPOLIS, MD. 21401 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 6 ANNAPOLIS MEM. GARDENS 7/10/98 ANNAPOLIS, MD. injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerat Service Licensee 22. Name end Address of Facility WM. REESE & SONS MORTUARY, P.A 23a. Partí. Enter the disease, or complidations that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heer feiture. List only one cause on each line. Approximete tnterval Between Onset and Death **Physician** /Medical tmmedlete Cause (Finel SEIZURE DISORDER disease or condition resulting in deeth) Examiner Due to (or as a consequenca of): Examiner physician end s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot): Box 68760 certificete be Physician/Medical Due to (or as a consequenca of) 80 Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? P.O. 2 3 ☐ Probably 4 Ø Unknown 1 Yes 2 No bengis d be det Records. by 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? Hes 2 No 1 des 2□ No Division of Vital or Attending Physician: director 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 X Yes 2 No 1 Inpatient 2X ER/Outpatient 3D DOA this funeral 27. Manner of Deeth 1 Natural 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending efter death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 Homicide Hospital 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of cartifier bute no O.C.M.E. JULY 7,1998 uns use of deeth (Item 23e) (Type, Print) 30. Nama and address of person who come 111 Penn Street, Baltimore, Maryland 21201 ennis lute m 31. Date filed (Month, Day, Year) 32 Figistrar's Signature whe Davidson-Randoll 1998 JUL 07

Registrar



State of Maryland / Department of Health and Mental Hygiene 8 2 1 3 9 6

			Certifi	cate of L	Death	Re	g. No.	41396				
Physician	1. Decedent's Nama (First, Middle, Las	st)				2. Data of Daath Month		3. Tima of Death				
/Medical	JESSIE		14001			JUNE		98 12; 25AM				
Examiner	4a Facility Name (If not institution, give Prince George's		enter		b. City, Town, or L heverly		4c. County o	George's				
Funeral	Social Security Number 6. S	ex 7. Age (In yrs.	. last birthday) If I	Undar 1 Year	If Under 24 Hrs.			9. Birtholace (Stete or Foreign				
Director	100 12 1001	□M 3√F 90	Yrs. Mo	nths Days	Hours Min.	Aug. 4		a.				
A =1	Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Locatio	n		,		10d. Inside City Limits				
notified at rector	Md Prince (George's Hya	attsvill	_e				Yes 2□No				
23a on	10e. Street and Number 4916 LaSalle Ro	d.	10	20782			g. Citizen of WI	nat Country?				
by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Was Decedant Evar in L Armed Forcas? 1 ☐ Yes 2 No If Yas, Give Year or Dates:		Dacedant of His, specify Cuba	spanic Origin? (S) n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black	- American Indian, White, etc. Vhite				
natural', soical Ex leted b	15. Decedent's Ed (Specify only highest gra		16a. Decedent's	Usual Occupa	ition luring most of work)	king 1	6b. Kind of Bus					
	Elementary/Secondary (0-12)	College (1-4or 5+)	Homema	RKer			home					
d other than event, me N Be Comp	17. Fether's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, M	alden Sumame)						
To Be	Newton	Allowa	ay		Alice		Wi	tter				
EE	19a. Informant's Name/Relationship (City or Town, S	itate, Zip Code)									
important: if item 27 is any injury or other trs pnce.												
7 0 E												
njury												
e ny C	Diac.	Burner.	Hage	erstow	n, Md.	21740		Oual Place				
sician edical miner	23a. Part1. Enter the disease, or companies, or heart fellure. List only immediate Cause (Final disease or condition resulting in death)	. HYPOTE			9, 9001 40 007040	or rospitatory and		Approximate Interval Between Onset and Death				
Iner	<u></u>	SEPSI						Imonth				
burial-transit	Sequentially list conditions,	Due to (Due to (or as a consequence of):									
buria	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events	· GANGRI			ECYSTI	TIS		lmonth				
use es the bur use es the bur in/Medical	resulting in death) Last	d	or as a consequand	a or):								
d for use	Part II. Other significant conditions or	entributing to death but not re	culting in the under	vina cause aix	on in Part I	23h Did tol	acco use con	tributs to the cause of death?				
igned by the ettending be detached for use of by Physician/M		INSUFFI					THE RESERVE	3 Probably 4 Unknown				
should should						24e. Was an perform	autopsy ed?	24b. Were autopsy findings available prior to completion of cause of death?				
page 2						1 ☐ Ye	s 2 No	1 Yes 2 No				
certificate rector, pag	25. Was case referred to medical examiner?				26. Place of Dee	th (Check only one)					
T die	1 Yas 2 No			DOA Othe	4 LI Nursing H	ome 5 Resider						
9 6	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury Work	rat (? ras 2 □ No	28d. Dascribe ho	w Injury occurre	od .				
od in by	3 Suicide 6 Could not be determined	28e. Placa of Injury - At I building, etc. (Special	nome, farm, street, f ify)	actory, offica		28f. Location (Str. City or Town,		r or Rural Route Number,				
To the Funeral Director: After to completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)	ysician: To the best of my kniner: On the basis of examinand manner stated.	owledge, death occ etion end/or investion	urred at the tim gation, in my of	e, date and plece pinlon, deeth occu	, end due to the ce rred at the time, da	use(s) end mar te and place, s	ner as stated. nd dua to the cause(s)				
To the comp	29b. Signature and title of cartifiar	2		29c. License				(Month, Day, Year)				
	Leighting	ahusto)	D5	3913		06- 8	75-98				
	30. Name and address of person who deleted to N H			u. D								
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign		, -								

PARTIES THE CO. NO. 12

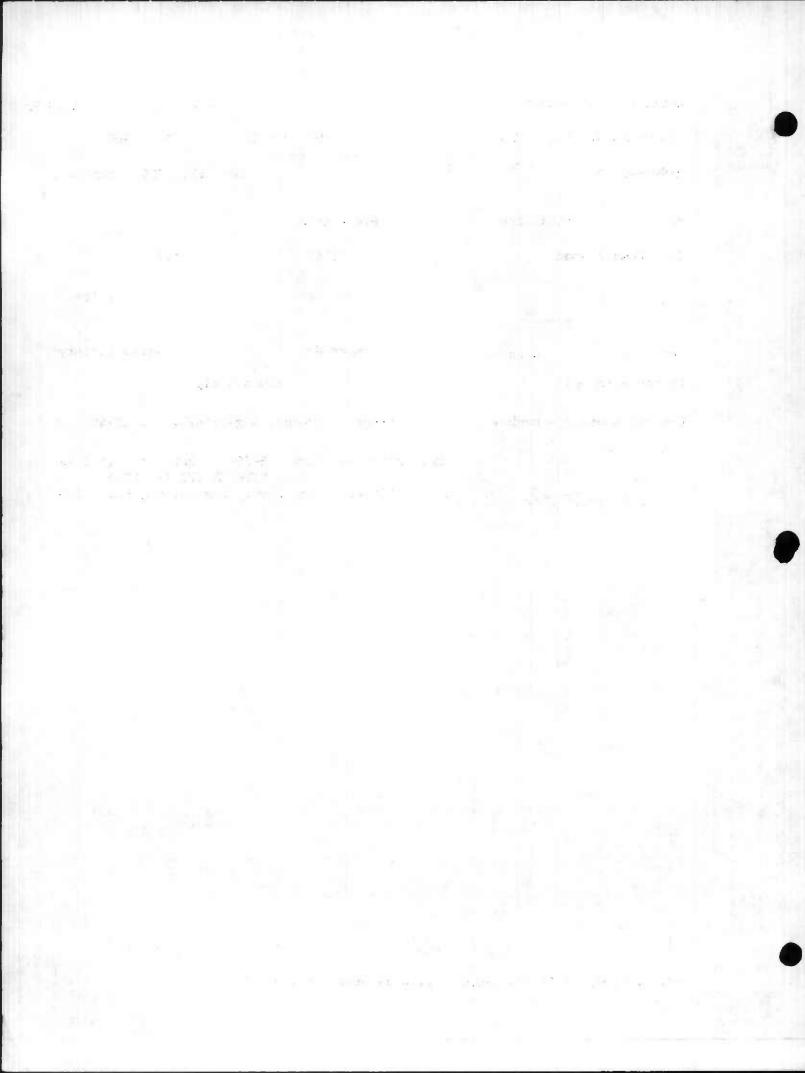
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 25 **Physician** Day 98 Lucille Irene HENSON 4;00 PM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not Institution, give street end number) 4c. County of Deeth Examiner RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON 5. Social Security Number If Under 1 Yeer if Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 X F Months Days Hours 73 Yrs Director 219-14-8695 June 11, 1925 Maryland Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location 28a-1 show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2K No MD Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 238 1632 Howell Road 21740 USA Funeral death Herra: 11 Merital Status 12. Was Decadent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 No Specify: white by 3 X Widowed 4 ☐ Divorcad naturs!', Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiene. Important: If fem 27 Is marked other than 7 any injury or other traumatic event, in a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Mental In a Elementary/Secondery (0-12) College (1-4or 5+) unknown seamstress dress factory unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be George Pitsnogle Maude Alsip 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Kenneth Nussear - nephew 721 Virginia Avenue, Hagerstown, Md. 21740 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 6-29-98 Hagerstown, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of) laurema The lew requires that the death certificate be executed Exami Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury buriel-tran Due to (or es a consequence of) P.O. Box 68760, physician Physician/Medical that initiated events resulting in deeth) Last the Due to (or as a consequence of) use as Po Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 ☑ Unknown Records. þ 8 Completed funeral director, page 2 should 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? peed completion of cause of death? certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred After 1 Neturel 5 Pending deeth. Investigation 1 Yes 2 No 2 Accident the 24 hours after deet Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical completely (Check only onel Within 2 To the å 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Dr. E. Moody, 1190 Mt. Aetna Rd., Hagerstown, Md. 21740 32. Registrar's Signature State wie Davidson-Randell

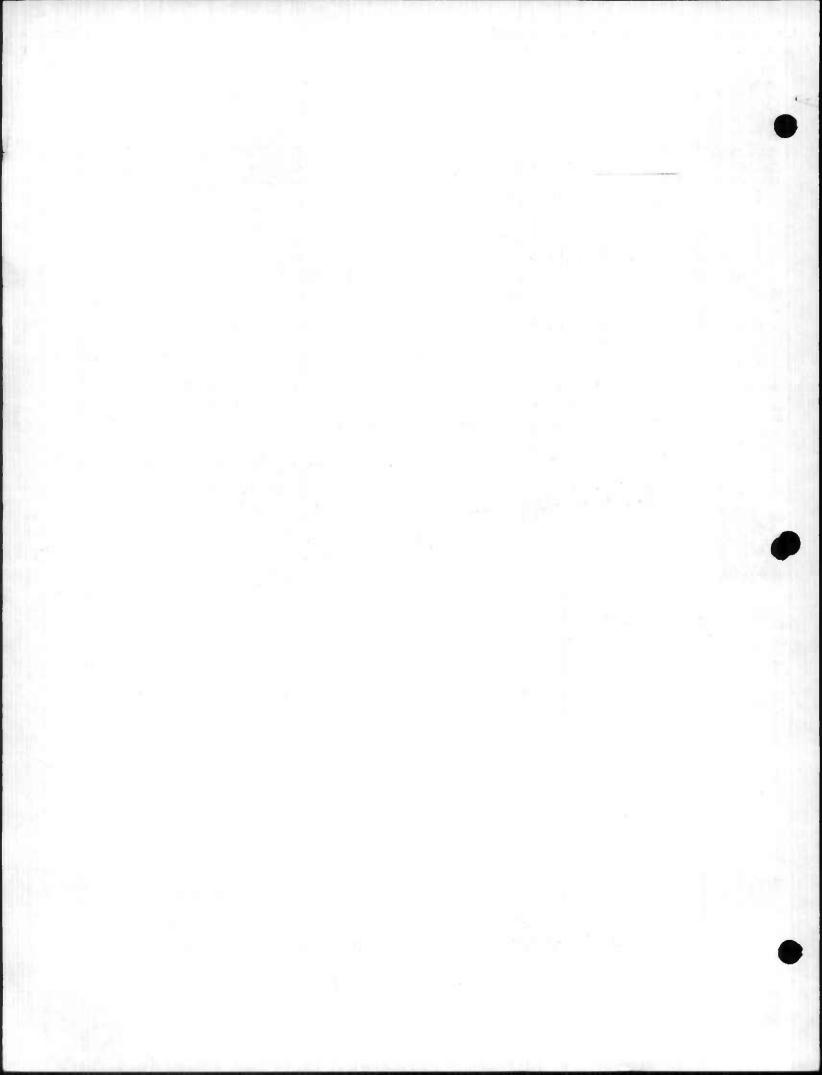
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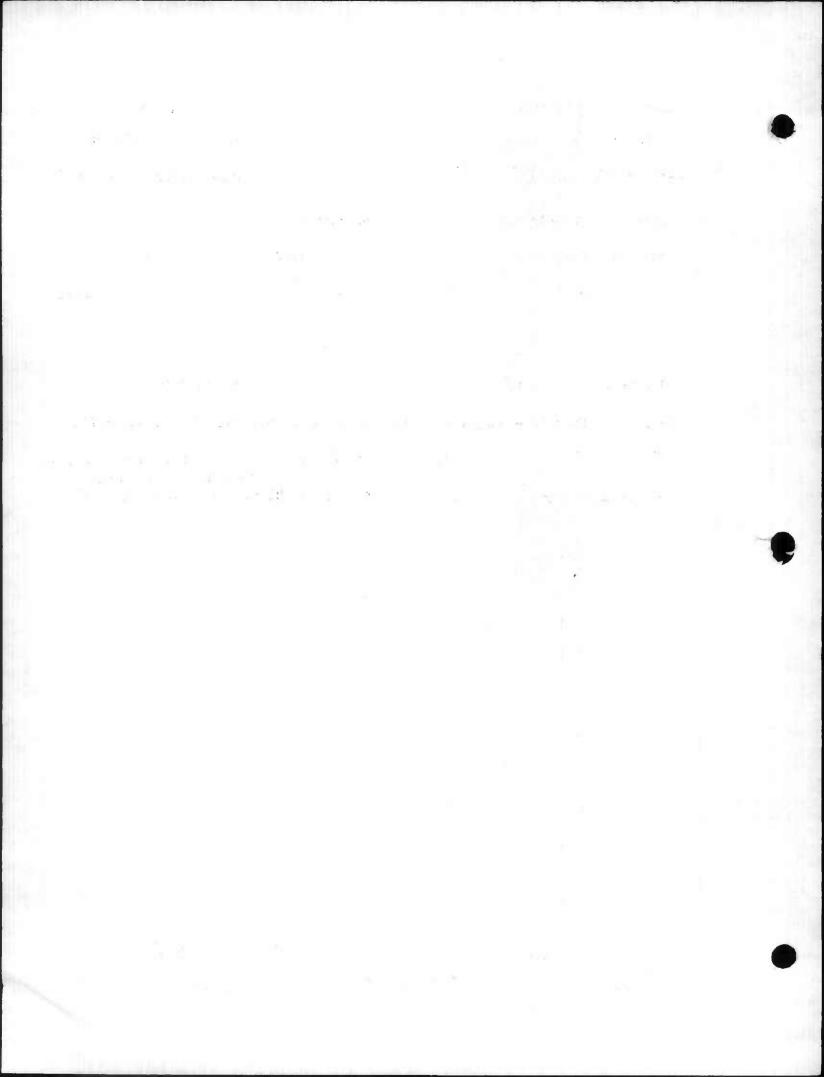
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28a-f sho	ctor	Md. Washing	ton	Ha	gerstow	m					1X Yas 2
8	Funeral Director	10e. Street and Number 702 Guilford Av	0.0011.0			10f. Zip Coda 21740			10g. Citizan o	What Cour USA	ntry?
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State of Maryland / Department of Health and Mental Hygiene

					Certifica	ate of	Death	R	leg. No.	61	399
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Many 1 sh	to	Maryland Washi	ngton		На	gerst	own				1 Yas 2 No
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should be filed nd Mental Hygi marked other umatic event, II	To Be	17. Fathar's Nama (First, Middle, Lest) Sylvester J. Pal	mer, Sr.					na (First, Middla, I Ethel R.		10)	
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of Hee		20a. Method of Disposition 1 ☑ Burlai 2 ☐ Cremation 3 ☐ F	Ramovai from Stata	20b. Piaca cema	of Disposition (/ tary, cramatory of	Vama of or other pla	ce)	Date	20c. Location -	City or Town	, Steta
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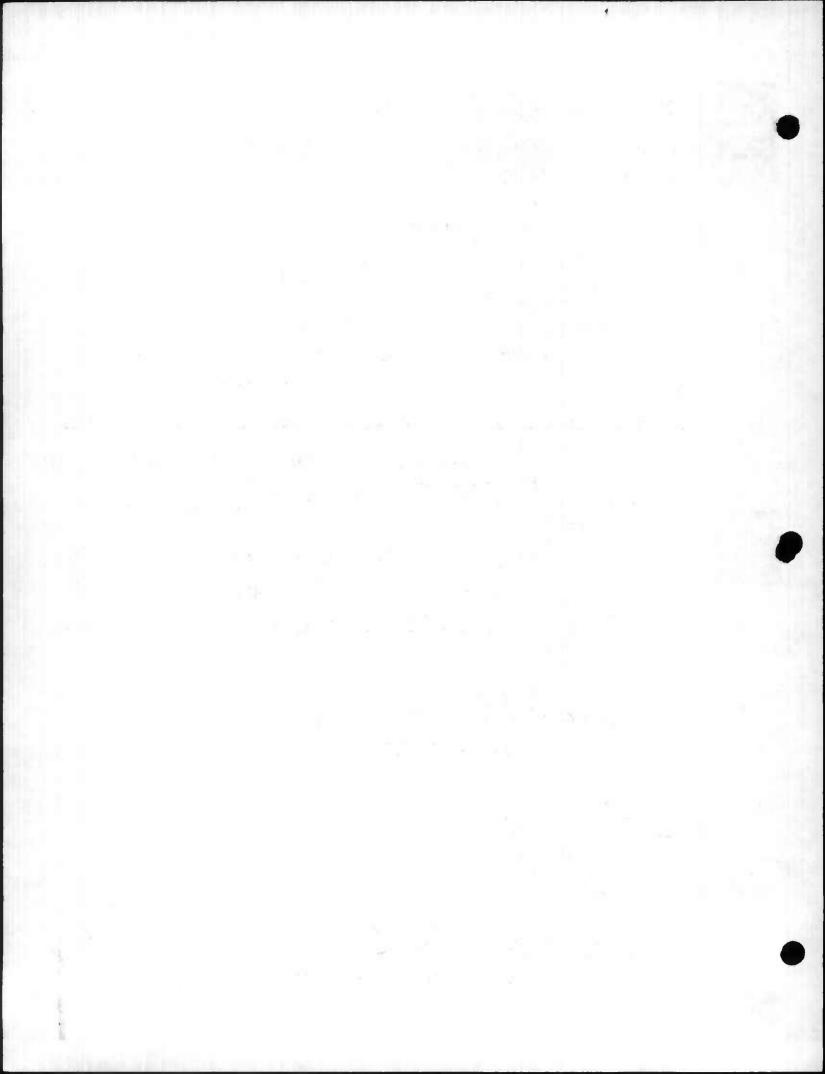
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death **Physician** THELMA HARMOR ADALADE /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva streat and number) 4c. County of Death **Examiner** HAGERSTOWN

If Undar 24 Hrs.
Hours Min.

B. Data of Birth
(Month, Day, Year) WASHINGTON COUNTY HOSPITAL WASHINGTON 5. Social Sacurity Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) **Funeral** Birthplace (Steta or Foreign Country) 1 ☐ M 2 TF 76 Months Days Director WASHINGTON, D.C. 220-09-7289 10/07/1921 Usual Rasidance of Dacadani death with the Maryland and Mental Hygiene. Is marked other than "naturel", or items 23a or 28s-f show raumatic event, if a Madical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Insida City Limits Director 1 ☐ Yas 2√ No MARYLAND WASHINGTON **BOONSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 21449 GREENBRIER ROAD 21713 U.S.A. Funeral 11. Marital Status 12. Was Dacedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours efter 1 ☐ Yas 🌂 X No If Yes, Give Yaar or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🗓 No Specify: þ Specify: WHITE 3 Widowad 4 Divorced Be Completed 15. Dacedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elemantary/Sacondary (0-12) Collega (1-4or 5+) YEARS BOARD OF EDUCATION SCHOOL TEACHER 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Surnama) ont of Health and Mental H t: If item 27 is marked oth y or other traumatic even RALPH VANCE POLLY HOFFMAN 2 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 21449 GREENBRIER ROAD, BOONSBORO, MARYLAND 21713 CHARLES E. HARMON, HUSBAND 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Surial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) permit. Page Department Important: If any injury or once. BOONSBORO CEMETERY JUNE 19, 1998 BOONSBORO, MARYLAND 21. Signature of Funeral Service Licensea P. 87 Dayfert R 22. Nama and Addrass of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME STEVEN DANFELT, JR. 21713 BOONSBORO, MARYLAND 23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical tmmediate Ceusa (Finat disaasa or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed buriel-transit Sequantially list conditions, if any, laading to Immadiata ceusa. Enter Undarlying Causa (Diseasa or injury that Initieted avants rasulting in daath) Last P.O. Box 68760. Physician/Medical Dua to (or as a consequenca of): the use as should be deteched Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by 3 Probably 4 ☐ Unknown -1 Yes 2 No Records, þ 24b. Were autopsy findings availabla prior to completion of ceusa of death? 24e. Was an eutopsy performed? Completed peen hes pege 2 2 1 No this certificate 1 Yas 1 Yas 2 No of Vital Hospital or Attending Physician: 25. Wes cesa referred to medicat axaminar? Be 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 DN 2 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28a. Deta of Injury (Month, Dey Year) Certification: 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? After Division 1 HNetural 5 Pending investigation sefter death. 1 ☐ Yas 2 ☐ No 2 Accidant in by the 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homloide within 24 hours e To the Funeral C Medical 29a. Cartifiar 1 🗹 Cartifying Physician: To tha bast of my knowledga, daath occurred at the tima, data and place, and dua to tha cause(s) end mannar es stated. 2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the causa(s) and manner stated. the th 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who complated cause of death (Item 23e m. SACHS, M 31. Dete filed (Month, Day, Year)
JUN 16 1998 32. Resistrar's Signature istrai's Signature handell V5/04 State

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Jane Marie Higgins June 12, 1998 1015 Pm /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12131 Hanging Rock Road Clear Spring, 8. Date of Birth (Month, Day, Year) Washington If Under 1 Yaar if Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2□ F 215-34-3449 62 Yrs. MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Washington Clear Spring Director 1 Yes No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 12131 Hanging Rock Road 21722 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armad Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. white 1 Nevar Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Giva Year or Datas: 1 ☐ Yes 2 ☐ Xo Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry residence Elementary/Secondary (0-12) 12 vears College (1-4or 5+) Homemaker years 18. Mother's Name (First, Middle, Maiden Sumame)
Margaret O'Leary 17. Father's Name (First, Middle, Last) Walter Suffecool 0 19e. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leister Higgins 12131 Hanging Rock Rd. Clear Spring, MD 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, Stata Blairsvalley Cem.June 16,1998 Clear Spring, MD 1XXurial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility
Thompson Funeral Home, Inc. auch P.O.Box 310 Clear Spring, MD 21722 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Immediate Cause (Finel Metartake Overian Cancer disaasa or condition rasulting in death) Due to (or as a consequence of): Examiner Sequentielly list conditions, if any, leading to immediate causa. Entar Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospital: 1 | Inpatlant | 2 | ER/Outpatient | 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 8 Other (Specify) Certification: To 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1. Melormack MD 6.15.98 P41667 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar Michael

31. Date filed (Month, Day, Year)

11110 Medical Campus Rd. Svite 130 Paperstown MO 21742 McCormack Hegister's Signature Randolle

the Maryland

death with

28a-f show

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinet must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mentel Hygiene. Important if Item 27 is marked other than "natural", or item any injury or other traumatic event. The Manten 1

Physician /Medical

Examiner

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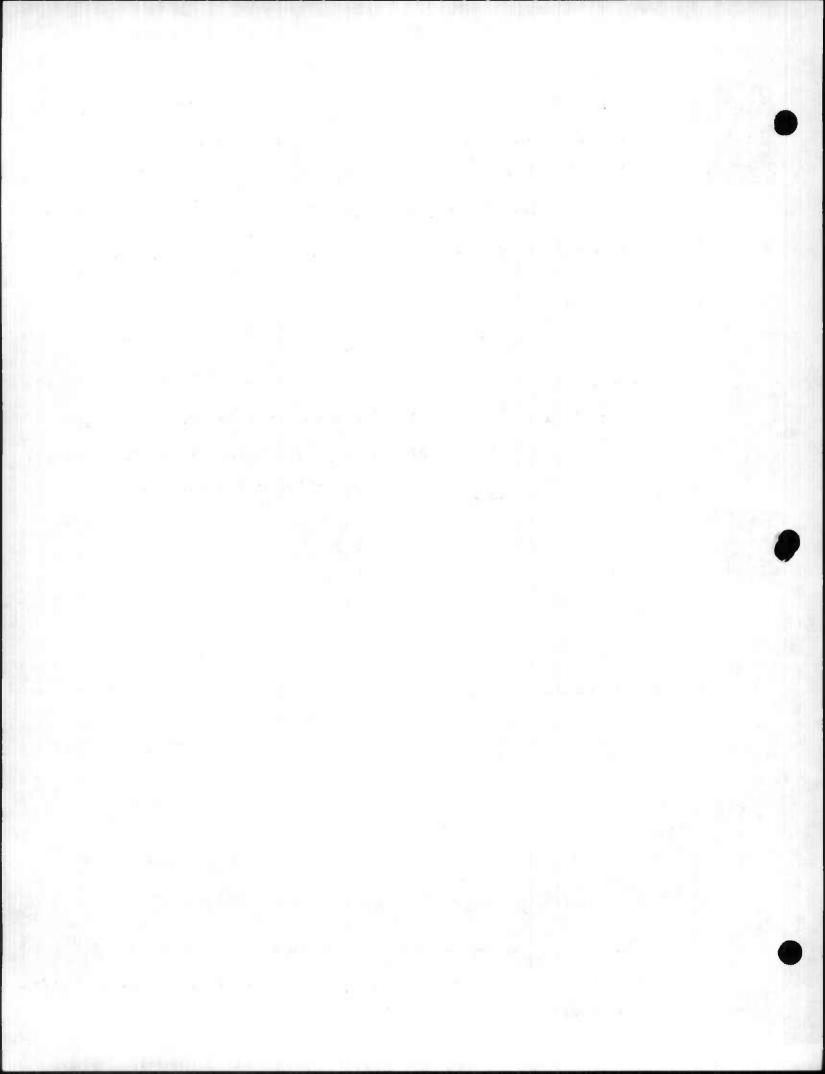
To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

P.O. Box 68760,

Division of Vital Records.

Baltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death

2. Data of Death

3. Tima of Death

Physician	
/Medical	
Examiner	

1. Decedant's Nema (First, Middla, Last)

. 1998 JUNE 22, BRENDA JOYCE HELBIG 2:50 PM 4a. Facility Nama (If not institution, giva straat and numbar) 4b. City, Town, or Location of Death 4c. County of Death GARRETT COUNTY MEMORIAL HOSPITAL OAKLAND **GARRETT** If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 8. Data of Birth Month, Day, Year) OCT 10, 1971 7. Aga (In yrs. last birthday) 9. Birthplece (Stata or Foraign **Funeral** 1 M 2 F Deys Hours 216-02-8247 Yrs MARYLAND Director 26 Usuai Rasidence of Dacedant death with the Maryland 10a. State 10b. County ral', or items 23a or 28a-f show Examinar must be notified at 10c. City, Town or Location 10d. Insida City Limits Director MD **GARRETT** OAKLAND 1 Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21550 USA 3440 WHITE CHURCH STEYER ROAD Funeral 12. Was Dacadant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ∑ No If Yas, Giva Yaer or Datas: Was Dacadant of Hispenic Origin? (Spacify Yas or No-If Yas, specify Cuben, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Examinations. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🖾 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collage (1-4or 5+) MANAGER FAST FOOD RESTAURANT 17. Fathar's Nama (First, Middle, Lest) 18. Mothar's Nama (First, Middla, Maldan Sumame) Be JOHN THOMAS SHAHAN, SR. JOANN LOUISE DURR 19a. Informent's Neme/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) WILLIAM M. HELBIG JR - HUSBAND 3440 WHITE CHURCH STEYER RD. OAKLAND, MD 21550 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 XBurlal 2 ☐ Cramation 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 6/25/98 DEER PARK, MARYLAND DEER PARK CEMETERY 21. Signature of Funecal Saprice Lig 22. Nama and Addrass of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Batween Onsat and Deeth **Physician** /Medical immediata Cause (Finel primitive neuroectodermal tumor disease or condition resulting in daath) 14 months **Examiner** Examiner or Attending Physician: The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, laading to Immediata causa. Enter Undarfying Causa (Disaase or Injury that initiated events rasulting In deeth) Last Due to (or as a consequence of): physician s the buriel P.O. Box 68760. Physician/Medical Dua to (or as a consequance of): 98 USB signed by the e Part It. Other significant conditions contributing to death but not rasulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? page 2 should 24a. Was en autopsy performed? certificate 1 Yas 2 XNo 1 ☐ Yas 2 ☐ No Division of Vital director, Be 25. Was cesa raferred to medicet 26. Place of Daath (Check only one) Hospital: 1 Inpatlant 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 this 28e. Data of Injury (Month, Day Year) Certification: 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. tnjury at Work? After 5 Panding Investigation 1 X Naturai te Hospital or Attending in 24 hours after death. The Funeral Director: After pletely filled in by the fun 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 29a. Certifiar (Check only one) Certifying Physician: To tha bast of my knowledge, daeth occurred at tha tima, date and piaca, and dua to tha ceuse(s) and mannar as stated. Medical completely 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of codifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D25759 June 22, 1998 30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print) Walter K, Naumann, M.D., PO Box 247, 106 Cemetery Road, Accident MD 21520

State

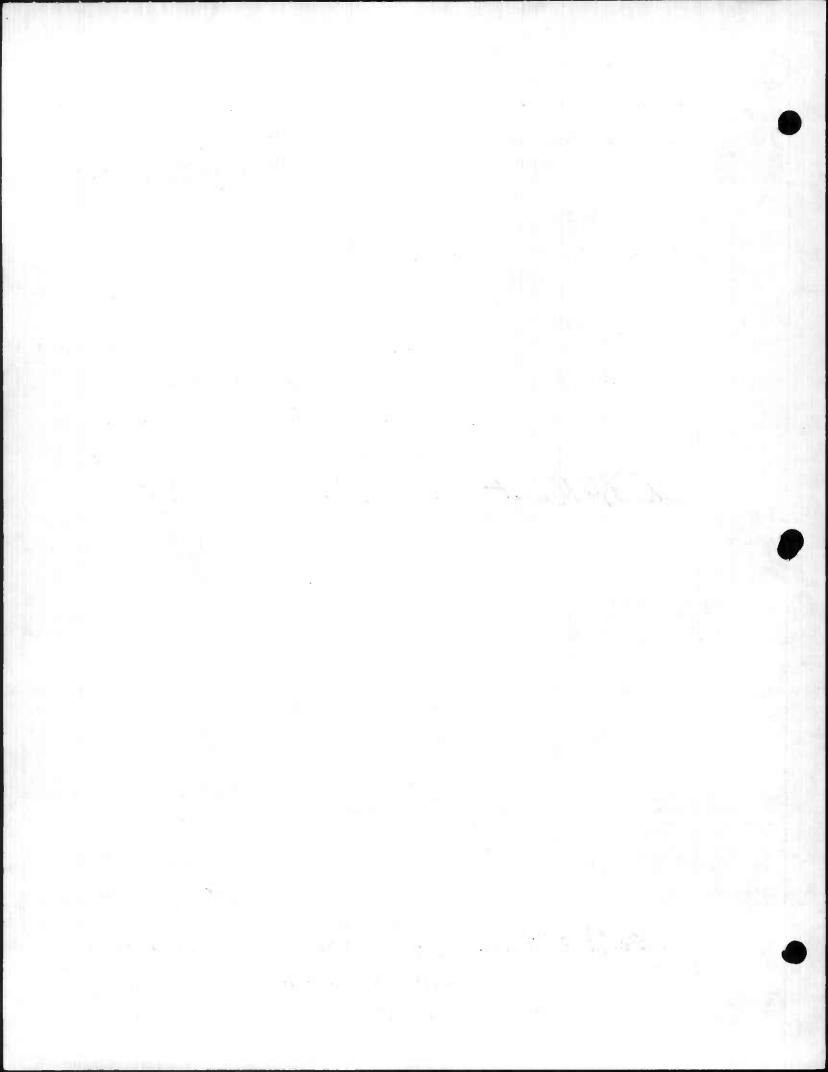
Registrar

31. Data filed (Month, Day, Year)

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32. Registrar's Signatura

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State of Maryland / Department of Health and Mental Hygiene

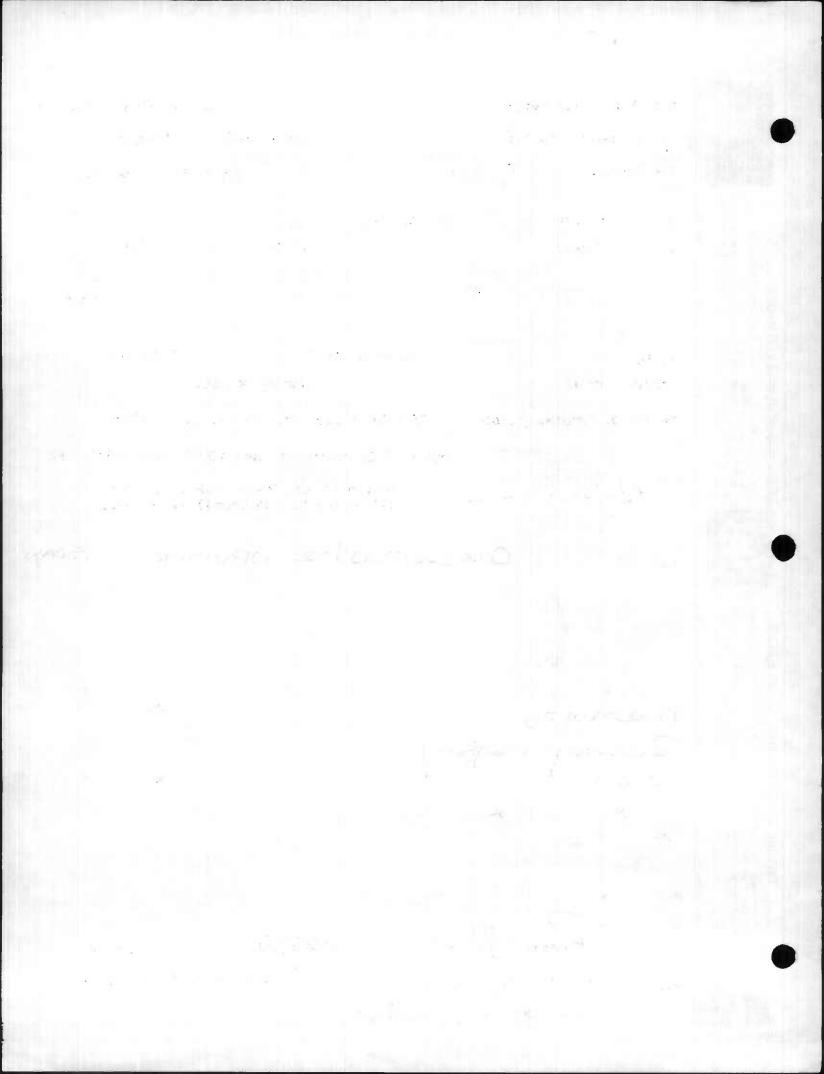
Certificate of Death Reg. No 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Ruth Marie Hershberger June 24,1998 0115 am /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Sacred Heart Hospital Allegany Cumberland 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs, lest birthday) Birthpiece (State or Foreign Country) **Funeral** Months Deys Hours 1 □ M 250 F 214-42-0215 Yrs. Director 93 Aug 8, 1904 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of health and Mental Hygiens. In the Maryland hygiens, with: if fem 27 la marked other than "naturel", or items 23a or 28a-f ahow any or other traumatic avent, the Medical Examinar must be notified at any or other traumatic avent, the Medical Examinar must be notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits No 2 □ No Director Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 141 Main Street 21536 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Meritel Stetus Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Detes: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Insurance Agent Insurance 12 th 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Andrew Maxwell Jenny / Bennett 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Daniel D. Hershberger/son 2621 Oak Valley Dr., Vienna, Va. 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 1 ☐ Burlel 2 X Cremetion 3 ☐ Removel from Stete permit. Page Department of Important: If any Injury or once. Country Side Crematory, June 25,98 Davidsville, PA 4 ☐ Donetlon 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licensee 22. Name end Address of Fecility Newman Funeral Homes, P.A., P.O. Box 275 23a. Pert1. Enter the disable, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or he in failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical immediate Ceuse (Finel diseese or condition resulting in deeth) Yna WFARCTION Examiner Due to (or es e consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be asscuted Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): attending p for use as signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yee 2 300 NO くところいく þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed i certificate has t director, page 2 s DE FUID 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: Attar this certific funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pinpatient 2 □ ER/Outpetient 3 □ DOA 1 Yes 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending Natural 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 5 4 Homicide .5 To the Hospital or within 24 hours aft To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred et the time, date end pieca, end due to the ceuse(s) end menner es steled.

| Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end pieca, end due to the ceuse(a) end manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end tive of certifier OBert 30. Name and address of person who com ted cause of deeth (Item 23e) (Type, Print), Cumberland 21502 1 902 Welik Seton Kobert 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

JUN 26



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2 Date of Death Month AWRENCE WILLARD 1998 JUNG 4c. County of Deeth 4e. Facility Neme (If Not institution, give street and number) 4b. City, Town, or Location of Deeth ARUNDEL GLEN ITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. (Month, Dey, Year) MAY 4, 1930 5. Social Security Number 6. Sex 9. Birthplece (State or Foreign Country) JAMESVILLE, N.C. 7. Age (In yrs. last birthday) 10XM 2□ F 68 214-26-0172 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1806 MALTRAVERS ROAD 21060 U.S.A. 12. Wes Decedent Ever In U.S. Armed Forces? XXYes 2 □ No 1946 − If Yes, Give Yeer or Detes: 1950 11. Merital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ◯XNo Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) N/A FOREMAN PUBLIC WORKS 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meidan Surname) COY RAY HOPEWELL NORA STEVENS 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BERYL HOPEWELL-WIFE 1806 MALTRAVERS ROAD GLEN BURNIE, MARYLAND 21060 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crametory or other plece) 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stete GLEN HAVEN MEMORIAL PARK 6/19/98 GLEN BURNIE, MARYLAND 4 Donation 5 Other (Spacify)

Physician /Medicai **Examiner**

important: If item 27 is marked

Physician

/Medical

Examiner

10a. Stete

Funeral

Director

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Itams 23a or

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altimore, Maryland 21215-0020

the Medical Examiner must be notified at

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The law requires that the death certificate be executed pue physician s the buriel

Division of Vital Records, P.O. Box 68760,

Attanding Physician:

ofter death Director:

signed by page 2 director, filled in by the within 24 hours e To the Funeral C completely filled

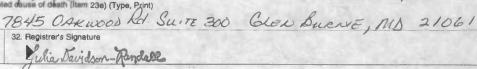
21	Signature of Funeral Service Licer	Karel	22. Name of SECO	end Address of Fecility SI	NGLETON FUNERAL LEN BURNIE, MAR	HOME, P.A. YLAND 21061
(Part1. Enter the diseese, or com	plications that caused the decone cause on each line.	eth. Do not entar the mo	ode of dylng, such es cardi	ac or respiretory errest,	Approximete Interval Between Onset end Deeth
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29	a. Cartifiar (Check only 2 Medical Exem	ysicien: To the best of my kn niner: On the basis of examin end menner stated.	owladga, daath occurre ation end/or Invastigatio	d et tha tima, date end pla n, in my opinion, daath oc	ce, end due to the ceusa(s) and mocurred at the time, date end place,	annar as stated. end due to tha causa(s)
298	b. Signature and title of Deptiller	e Kapla		25611		16 (Month, Day, Year)

State Registrar

30. Name and address of

IRA E. KAPLAN, MD

31. Dete filed (Month, Dey, Year)



of death (Item 23e) (Type, Print)

Service And the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Contr

Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** 1.30 Am unic RUDOLPH HOLUB /Medical 4a Facility Nema (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner - ARuniski MORTH ARUNDEL CHEN BURNIE AMNE GURNAL If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Defe of Birth (Month, Dey, Year) 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours Yrs. Director 92 132-10-2419 JUNE 28, 1905 NEW YORK Usual Residence of Deceden the Marylend permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Mexical Examiner must be notified at other. 10a. State 10b. County 10c. City. Town or Location 10d. fnslde City Limits 1 ☐ Yes 2 No Directo MARYLAND ANNE ARUNDEL BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7858 OYSTER SHELL COURT Funeral 21226 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 ☐ Married Specify: WHITE 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN PORTER RESTAURANT 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Be RUDOLF HOLLIB KATHERINE **HEZOUIKA** 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BALTIMORE, MARYLAND 21226 MARY ELLEN PETERS (NIECE) 7858 OYSTER SHELL COURT, Date 20a. Mathod of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY, INC.6/19/1998BELTSVILLE, MD

/Medical

Rudolph Holub

Physician Examiner

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Division of Vital Records, P.O. Box 68760,

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Examiner Physician/Medical þ Completed Be 10 funaral Certification:

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Due to (or as e consequence of): 320CTATIC Dua to (or as a consequence of)

22. Nama and Addrass of Facility

SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061

List only one ceuse on each lina.

Approximate

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

1 Yes 2 No 3 Probably 4 Unknown 24e. Was en autopsy performed?

24b. Were autopsy findings available prior to complation of causa of death?

1 Yes 2 No

CHEN RURNIE 21061

1 Yes 2 No

Approximate Interval Between Onset end Deeth

25. Was cese referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

28e. Date of Injury (Month, Dey Year) 1 Naturel 5 Pending 2 Accident investigation 6 Could not be 3 Suicida

1 ☐ Yas 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28a. Place of injury - At home, ferm, street, factory, office building, atc. (Spacify)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner es stated.

29b. Signeture, and title of certifian 58

4 - Homicide

(Check only one)

29a. Certifier

29c. Licansa number MD 145149

DRIVE

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signad (Month, Day, Year) June 15 1998

23b. Did tobacco use contribute to the cause of death?

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print) ONARAJO. HOCPITAR 301

2

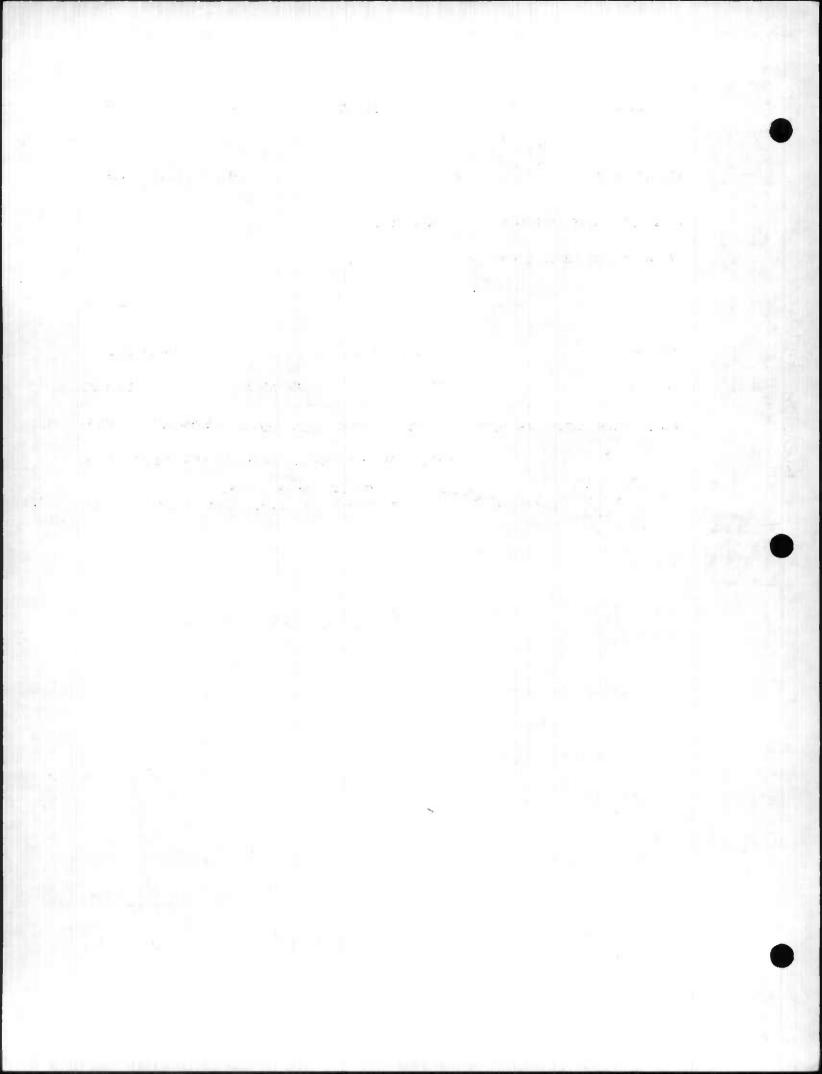
JUN 18 1998

31. Date filed (Month, Dey, Yeer)

32. Registrar's Signature

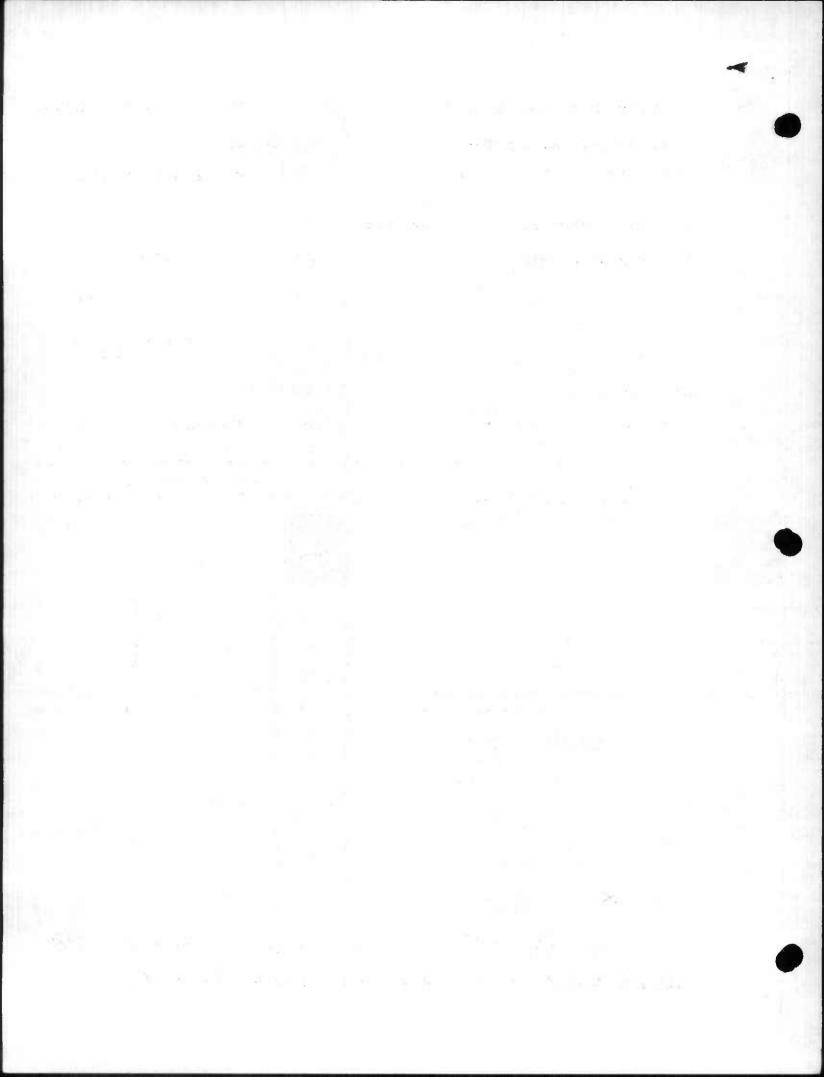
Mandelle. Felia Davidson

State Registrar

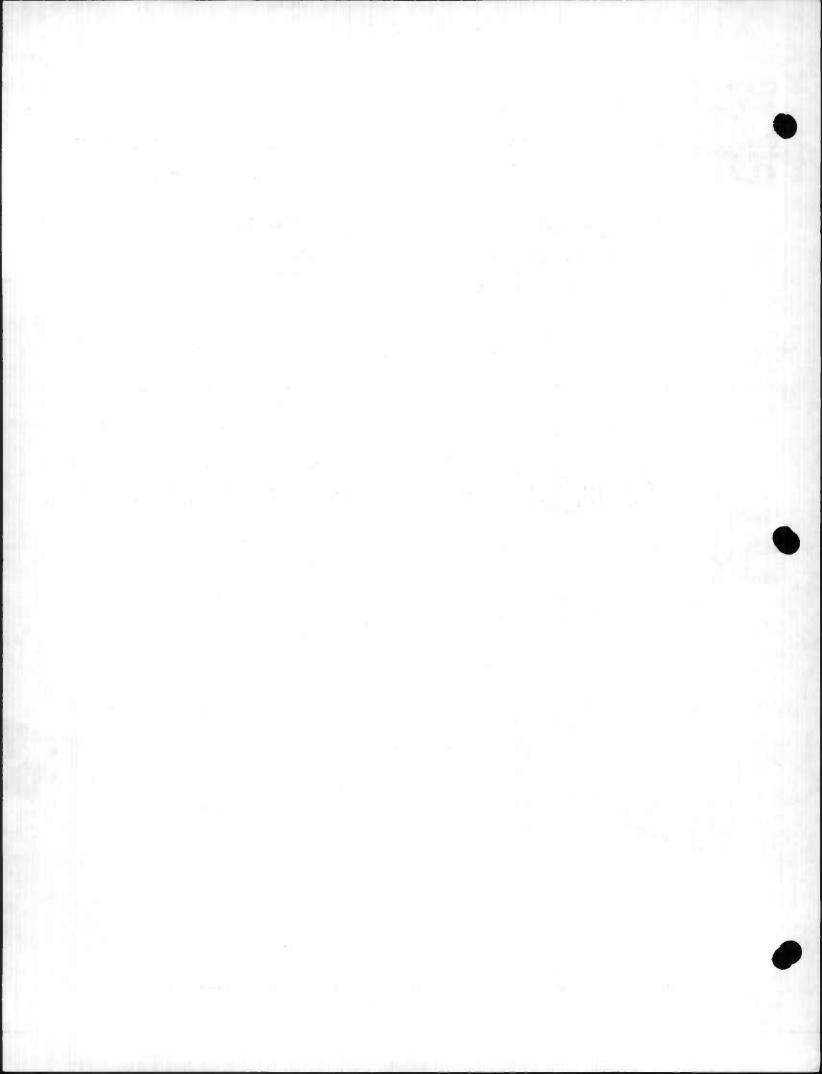


State of Maryland / Department of Health and Mental Hygiene 9

	-				.,	Certific		Death		Reg. No.	6	140	0
r	Dhusisi		1. Decedant's Name (First, Middle, Last)						2. Dete of Dea	ath	Vaar	3. Time o	of Death
	Physici /Medi		HOWARD MICHAEL	ISEMINGER	, SR.				JUNE	30 19	98	12:4	5 AM
)	Examir		4e. Facility Nama (If not institution, giva s	treet and number)				4b. City, Town, or L	ocation of Death	4c. County	of Death		
			Williamsport Nur					Williams			hingt	on	
	Funeral Director		5. Social Security Number 6. Sex 214-09-3459 Usual Rasidance of Decedant	7. Aga	(In yrs. last bi	Yrs. H Un Mont	hs Days		8. Data of Birth (Month, Day May 22			ice (Stata y) Land	or Foreign
	ahow at at	-	10a. Stata 10b. County		10c. City, Tov	n or Location					10	d. Inside C	
	N of L	octo	Maryland Washingt	on	Hag	erstown							2 🖾 No
	with	듑	10e. Street and Number			10f.	Zip Code			10g. Citizen of V		y?	
	eath m 23	era	18730 Northridge Di	1VE 2. Wes Decedent E	ver in II S	13 Was De		742 Hispanio Origina (Sr	anifu Vac or No-	U.S.A	e - America	n Indian	
21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Menyland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic event, the Medical Examines must be mortified at ance.	by Funeral Director	1 Navar Married 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yeer or Datas:			s 2 No	dispanto Origin? (Span, Maxican, Puarto Specify:	Rican, atc.)	Biad Specify	k, Whita, e		
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ø,	Heali Final		Howard M. Iseminger 20a. Method of Disposition	., 51 5	20b. Place 0	of Disposition (Name of		Data	20c. Location -			
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Ő,	o exe	E	Sequentially list conditions, if any, leading to immediate cause. Entar Indantying Cause (Disease or Injury that initiated evants										
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9 ×	2 2 9		d										
P.O. Box	eath cert attendin I for use	lan											
o	the de	Physician/	Part II. Other significant conditions con	ributing to death but	not rasuiting i	n tha undarlyin	ig causa giv	van in Part I.	23b. Did t	obacco use cor	* A		of death?
	The law requires that the death cer are been signed by the attendir page 2 should be detached for use		Conge	store H	cart	Fail	use		101	/es 2□ No	3 Probe	ibly 4	Unknown
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28a-f show	Director	10a. State MARYLAND		HINGTO	ON	10c. C	ity, Town or Lo	ocation		BOONS	BORO			1	0d. Inside City Limit 1 ☐ Yes 2 ☒ N
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If Yes, Give
Yeer or Detes: 1962 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16e. Decedant's Usuel Occupetion 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highast grada completed) College (1-4or 5+) Elamentery/Secondery (0-12) Aluminum Manufacturer Senior Project Engineer 18. Mother's Name (First, Middle, Maidan Surname) 17. Fether's Neme (First, Middle, Last) Eure Merwinn Jenkins, Sr. Elizabeth Hudgins Jenkins 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Raletlonship (Type, Print) 13823 Woodland Heights Drive, Hagerstown, MD 21742 Edith T. Jenkins, Wife 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremation 3 ☐ Ramoval from Steta Smithsburg Crematory June 26 Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama end Address of Fecility
Douglas A. Fiery Funeral Home 21. Signature of Funerel Service Dicenses ownk 331 Eastern Blvd. N., Hagerstown, Maryland 21742 disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, i.e. List only one sause on each line. Approximete Intervel Between Onset end Deeth immediate Causa (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Couse (Disaese or Injury thet initiated evants resulting in death) Lest Dua to (or as a consequanca of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other stanificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? complation of ceuse of death? 2 110 1 ☐ Yes 2 ☐ No 25. Was casa raferred to madical exeminer? 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2DER/Outpatient 3□ DOA Certification: To 27. Mennar of Deeth 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of Naturel 5 Panding 1 Yes 2 No investigation 2 Accident 6 Could not be datarmined 3 Suicide 28e. Plece of Injury - At home, farm, straet, factory, office building, etc. (Specify) 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) 4 Homicida 29e. Certifier Certifying Physician: To the best of my knowledge, daeth occurred et the time, dete end plece, end dua to the ceuse(s) end menner es stated. Medicai (Check only one) 2 Msdlcal Examinar: On the besis of examinetion end/or invastigetion, In my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) end menner stated.

State Registrar

completely

29b. Signeture and titla of certifier

31. Dete filed (Month, Bey Need) 9 1998

Martha A.

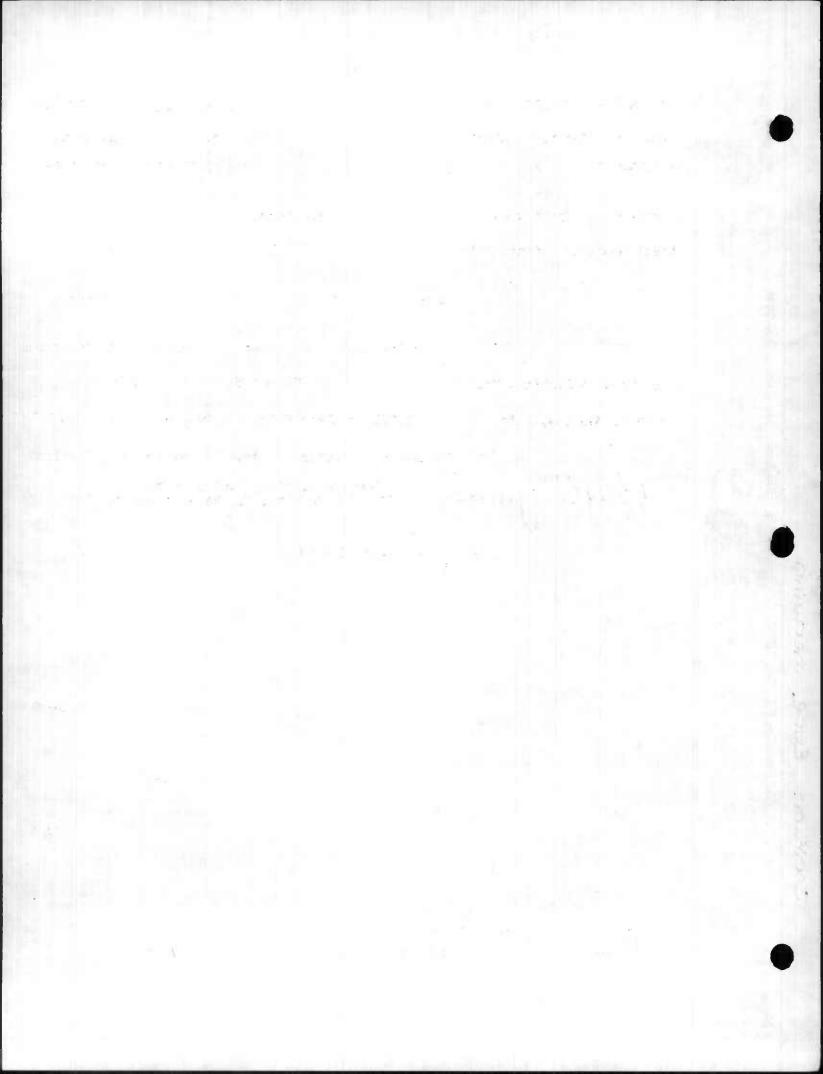
within 2 To the

> 11110 Medical Campus Road Julia Davidson

30. Name and addrass of person who complated ceusa of daeth (Item 23a) (Type, Print)

Riggle MD

29c. Licensa number



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth **Physician** Month Vear TOHN Ε. JANNUZI JUNE 1998 /Medical 17;45 4e. Facility Neme (If not institution, give street end number) 4b City Town or Location of Deeth 4c. County of Deeth Examiner AVALON MANOR HAGERSTOWN WASHINGTON If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number If Under 1 Yeer & Sev 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 112 M 2□ F Yrs. Director 178-12-5270 2 - 13 - 21BEAVER FALLS PA Usual Residence of Decedent the Maryland 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 Yes 2 No Director PA FRANKLIN CHAMBERSBURG 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 2946 PAXTON CT. 17201 U.S.A. death Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

1∑ Yes 2 □ No
If Yes, Give
Yeer or Detes: 1943-52 11. Maritel Stetus 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after onent of Health end Mental Hygiene. nt: If Item 27 is marked other than "natural", or ite 1 Never Merried 20 Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15 Decedent's Education 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 6 SUPERINTENDENT OF SCHOOL EDUCATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be RAPHAEL **JANNUZI** 0 TERESA STLVESTER 19e. Informent's Nema/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MARGARET **JANUZZI** 2946 PAXTON CT. CHAMBG. PA 17201 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete Burial 2 Cremetion 3 proposed from State 4 Donetion 5 Other (Specify 50 permit. Pege Department of Important: If any Injury or PARKLAWNMEM. GDNS. 6/23/98 CHAMBG. PA 22. Neme end Address of Fecility vioe L R.G. SELLERS F.H. NC. 297 PHLA. AVE. CHAMBG. PA ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, i. List only one cause on each line. Approximete ntervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel Phemons. 2-3-50 diseese or condition resulting In death) **Examiner** Due to (or es e consequence of): Examiner Casentin Fairlus 2-3-4 the bunel-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequença of): Reme End Slige Dinean Physician/Medical Due to (or es e consequenca of): 80 ding etter signed by the 4 d be deteched 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? actus melliller, suspendione, com 1 Yes 2 No 3 Probably 4 Unknown þ aneur, Anteno relente cardio -24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? Periplene Dinen certificete 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nurstrig Home 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 5 Pending 1 Naturel or Attending effector: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours off To the Funeral Di completely filled is 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the ceuse(s) end menner stated. Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) _ conta mo Jun 18, 1978 D(8015 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

31. Dete filed (Month, Dey, Year) JUN 19 1998



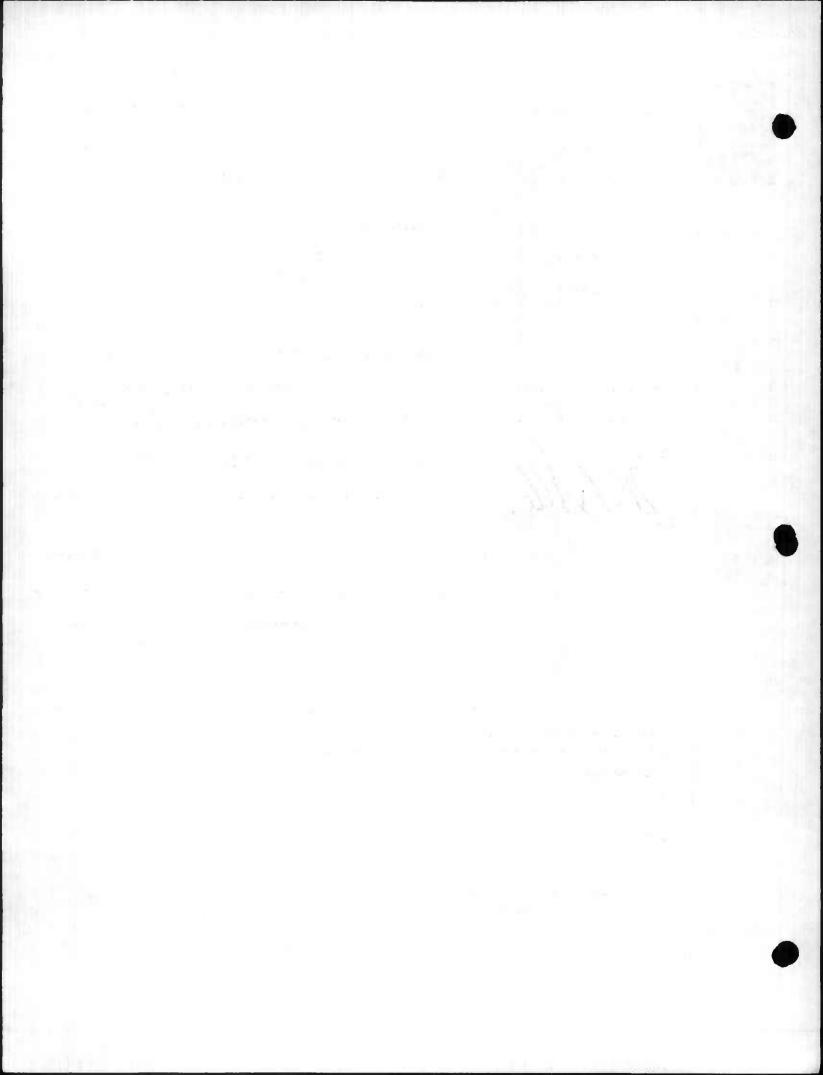
Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Yea Month **Physician** Thomas Wilmer Jackson June 26 1998 065. /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 12 19 Birthplace (State or Foreign Country) 6. Sex 12 M 2□ F 7. Age (In yrs. last birthday) Months Days Hours 215-18-4897 75 1923 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 U.S.A 518 Overbrook Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, While, etc. 1 Never Married 2 Married 1□ Yes 2No Specify: Specify: à 3 Widowed 4 Divorced Year or Dates: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fred Jackson Bessie Morris 19b. Malling Address (Street and Number or Rurai Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 518 Overbrook Drive Salisbury, Md. 21801 Vivian Jackson (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ceiff. 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from State St. James Free Meth. Church % Quantico, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility
Stewart Funeral Home West Rd. Salisbury, Md. 21801 lad 23a. Part1. Enter the district, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Due to or es a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 3 Probably 4 9 thknown 1 ☐ Yes 2 ☐ No þ Completed 24b. Were autopsy findings eveileble prior to 24a. Was an autopsy completion of cause of death? 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 28e. Dale of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - Al home, farm, streel, factory, office building, etc. (Specify) 4 Homicide

homes Jackson 215-18-489. Division of Vital Records, P.O. Box 68760

The law requires that the death certificate be executed

or Attending Physician:

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Marylend Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturs!", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examination and page.

Physician /Medicai

Examiner

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s certificate has the director, page 2 s

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24 hours Hospital

To the Hosp within 24 ho To the Fune completely fi

Baltimore, Maryland 21215-0020

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29d. Date signed (Month, Day, Year)

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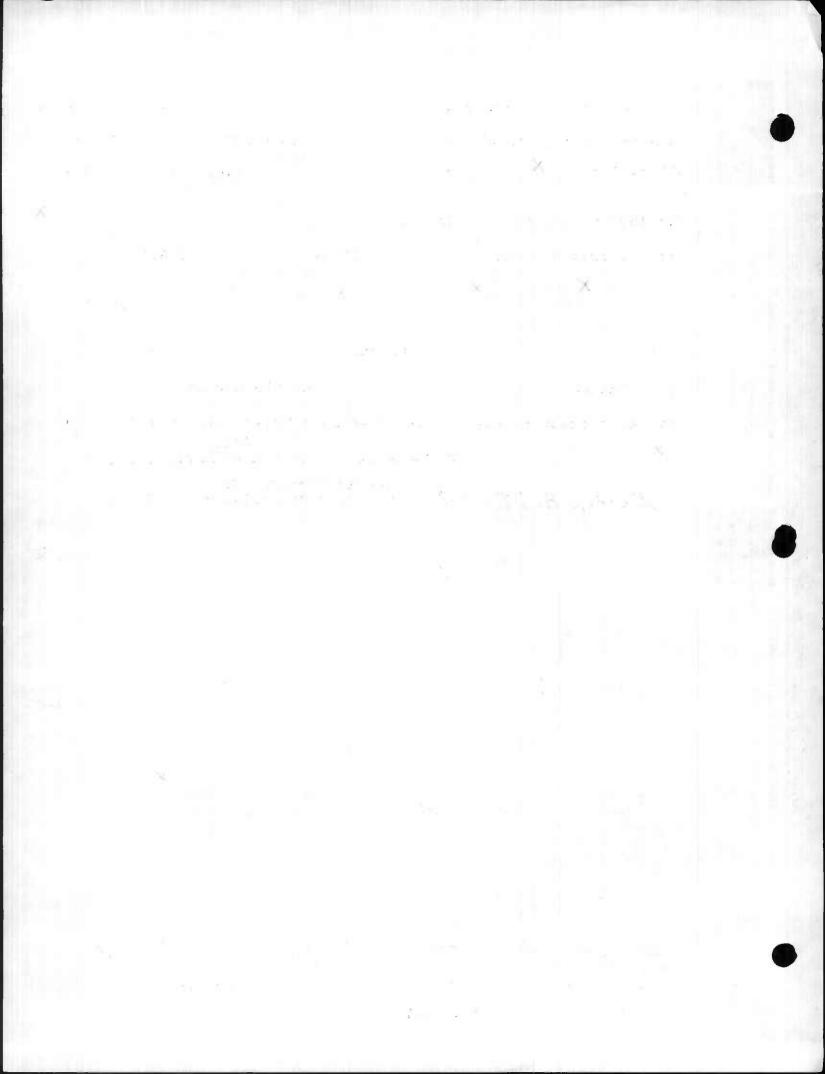
1 🗓 Confifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

William H.Robins Rt.50 &East Main St.Salisbury, Md.21801

32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 29 1998 Will okuster Raidall



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician JOHN** MARTIN KLINE JUNE 1998 12:05 AM 30 /Medical 4e. Facility Nema (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner COLTON VILLA NURSING CENTER HAGERSTOWN WASHINGTON If Under 24 Hrs. B. Dete of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Yaar 6 Sex 7. Age (In yrs. last birthdey) 9. Birthplace (Stete or Foreign **Funeral** 1X0 M 2□ F Months Deys MARYLAND Yrs. 88 Director 215-05-7294 Usuel Residence of Deceden with the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or ferms 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 11 Yas 2 □ No Director MARYLAND WASHINGTON HAGERSTOWN 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 510 EAST FRANKLIN STREET EXT. 21740 U.S.A. death 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or iter eny injury or other traumatic event, the Medical Examina-1⊠Yes 2□No If Yes, Give Yeer or Datas: 1 □ Never Married 2 N Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) ANIMAL CARETAKER DISEASE RESEARCH 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) CURTIS KLINE CLEMMIE SHEPLEY 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) EVELYN E. KLINE/SPOUSE 510 E. FRANKLIN ST. EXT., HAGERSTOWN, MD 21740 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetary, cremetory or othar piace) Data 20c. Location - City or Town, State 1 ⊠ Burlal 2 □ Cremetion 3 □ Ramovel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) BOONSBORO CEMETERY 7/2/98 BOONSBORO, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Addrass of Fecility 7606 Old NationalPike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only ona ceusa on each line. Approximete Intarval Between Onset and Deeth **Physician** PISTEMAGE /Medical Immediate Cause (Final ATHEROSCLEROTIC CARDIO VASCOLAR.

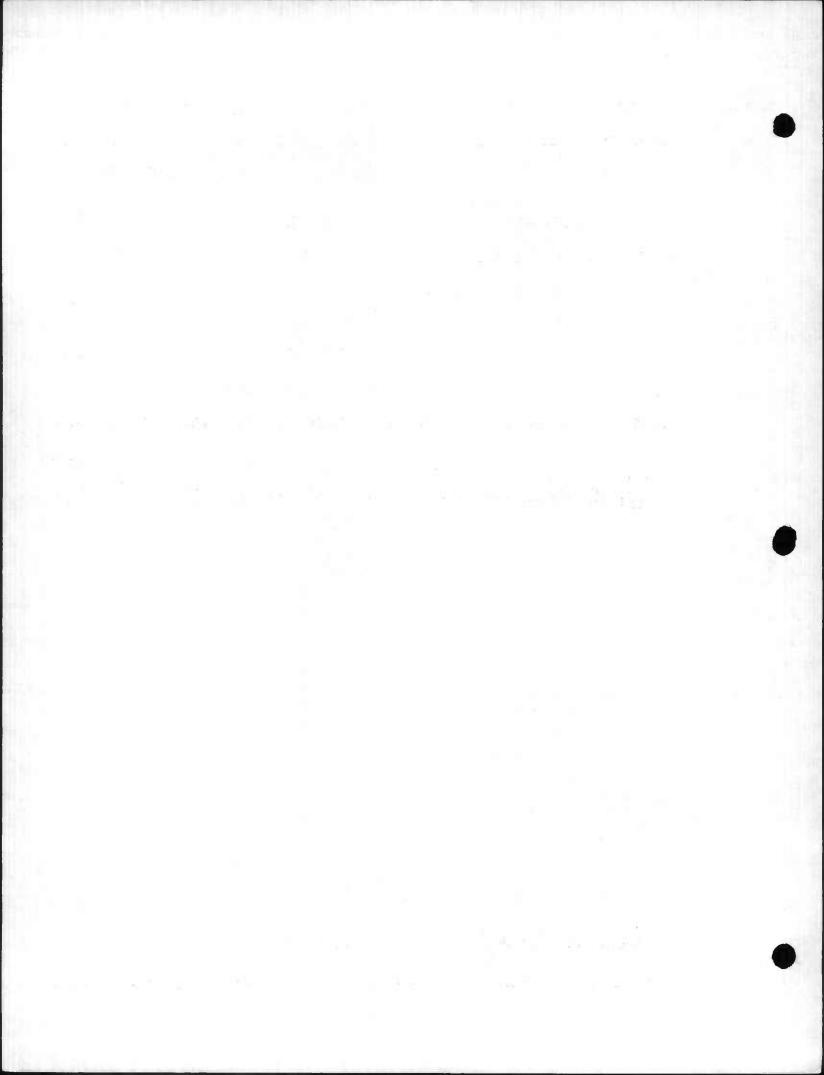
Due to (or es a consequence of): disease or condition resulting in deeth) 54-las Examiner Examiner HROWIE OBSTRUCTIVE AIRWAY DISBASTED Due to (or es a consequence of): sician and burief-transit Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last physician as the burief 5 years Division of Vital Records. P.O. Box 68760. DEMETIA Physician/Medicai Dua to (or as a consequenca of): attending signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown More by should I 24b. Were autopsy findings aveilable prior to completion of causa of death? 24e. Was an autopsy performed? Completed 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Affer 1 Neturel 5 Pending 1 Yes 2 No NA death. NIA NIA 2 Accident investigetion or Attend efter death Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stefe) To the Hospital or Atterwithin 24 hours efter dea To the Funeral Director completely filled in by the 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide NA NA 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the cause(s) end manner as stated. 29e. Certifier Medical 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. (Check only one) 29b. Signaturé end title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 10-30-94 D2x365

State Registrar 19 AOU 2

JUN3 0 1998 32. Registrar's Signeture Lulia Davidson-Randell

368 MILL STREET HAGERSTOWN MO 21740

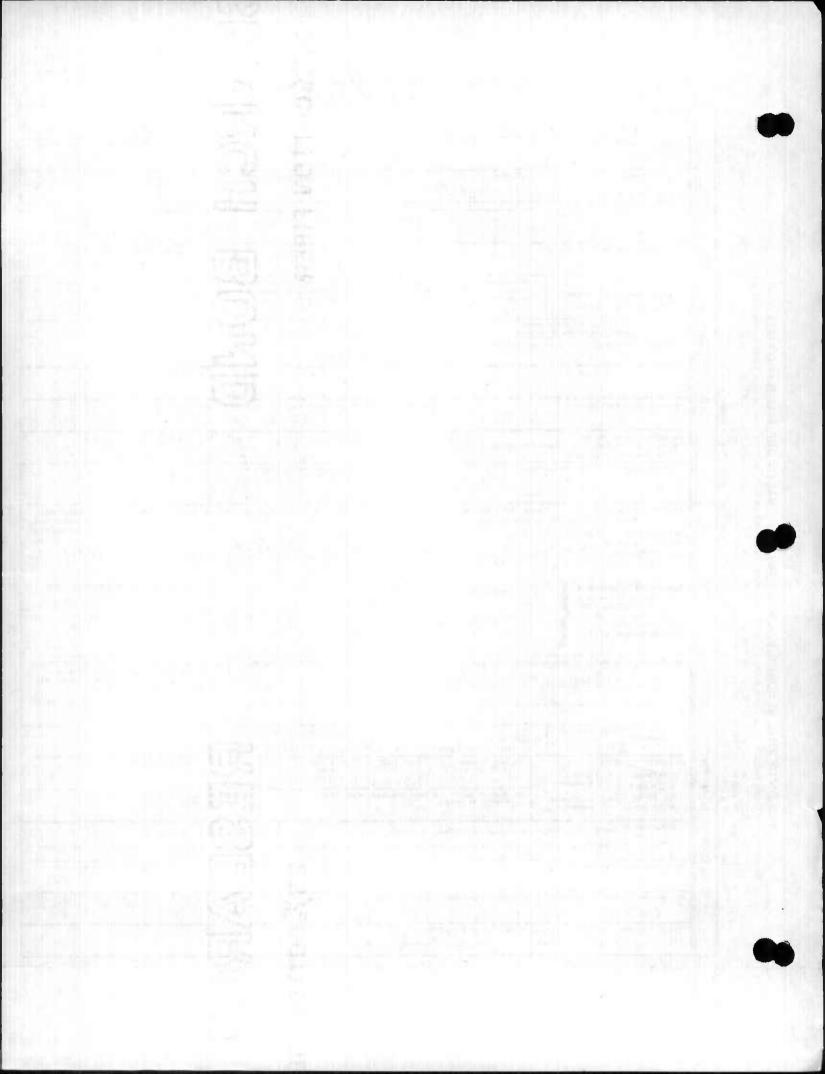
30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)



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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a floring mitter death. Page 6 may be retained by the hospital or attending physician.) THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burlal, cremation, or remonal.	JOHN 28 is marked or item 23 shows any injury or other fraumatic event the medical examiner must be notified at new
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	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTI	MENT OF H	EALTH AND I	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Las MARY ELIZ	ABETH KOO				2. DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DATE OF DEATH DATE OF DEATH DATE OF DATE OF DEATH DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DAT	AY	YEAR	3. TIME OF DEATH 1:45 A, M		
	4. SOCIAL SECURITY NUMBER 214-16-0873	5. SEX 6. AGE (In	yrs. last birthday)	F UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	/	BIRTH	PLACE (State or Foreign		
TOR	SO. FACILITY NAME (If not institution, give	estreet and number) PSING HOME	9	Hager	R LOCATION OF DI STOWN	EATH	Wash				
DIRECTOR	10a. STATE 10b. COUN	hington		gerstow				10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	100. STREET AND NUMBER 214 Hage	r St.		101	21740			S.A	HAT COUNTRY?		
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 SNO	If yes, sp		HC ORIGIN? (Specify Yes in, Puerto Rican, atc.) y:	or No- 1	4. RACE Black Specif	- American Indian, White, etc.		
COMPLETED	15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12)		Iffe. Do NOT use i	k done during mo	st of working	166. KIND OF BUS		STRY	SELLI		
BE COMF	17. FATHER'S NAME (First, Middle, Lest)	Clyde N. Koon		acy wor	16. MOTHER'S NA	ME (First, Middle, Meiden ry Catherin	Surname)	meri	man		
TO B	190. INFORMANT'S NAME (Type/Print) Jan	e Koons	19b. MAILING AI	4 Hager	St. Hag	Route Number, City or Town Jerstown, M	n, State, Zip 0 1d. 21	740			
	20e. METHOD OF DISPOSITION ME Burlel 2 Cremetion 3 Re 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	camel	PLACE AND DATE OF Pery, crematory or othe	Zimmer	r Hill tery man And	6/27/98 Gr Son Funera		stle	e, Pa.		
CERTIFICATION	Greencastle, Pa. 17225 23. PART I. Enter the disease, pr complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List pnly one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL CI	PART II. Other eignificant condition	one contributing to death bu	that resulting in	the underlying	cause given in	Part I. 24a. WAS AN PERFOR 1 TYES 2	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
ICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		THER:	ACE OF DEATH (Ch			_			
BY PHYS	27. MANNER OF DEATH 1 Netural 5 Pending	1 Inpetient 2 ER/Outpet 26e. DATE OF INJURY (Month, Day, Year)	26b. TIME (OF 28c. INJ	URY AT RK?	6 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCU	RED			
	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	26s. PLACE OF INJURY -	At home, farm, stre	et, factory, offic		281. LOCATION (Street e City or Town, State)		r Rural A	loute Number,		
COMPLETED		SICIAN: To the best of my knowled) and manner se stated.		
TO BE C	29b. SIGNAPURE AND TITLE OF CERTIF	han			29c. LICENSE NUI	MBER 55	-		(Month, Day, Year) 25, 1998		
-		TNA RD. 7	HAgens.	TOWN,	MD o	31140					
	31. DATE FILED (Month. Day, War)	32. REGISTMAN'S SIGNAT	rune /- rdson-Ra: id	rle							



FOR

21413

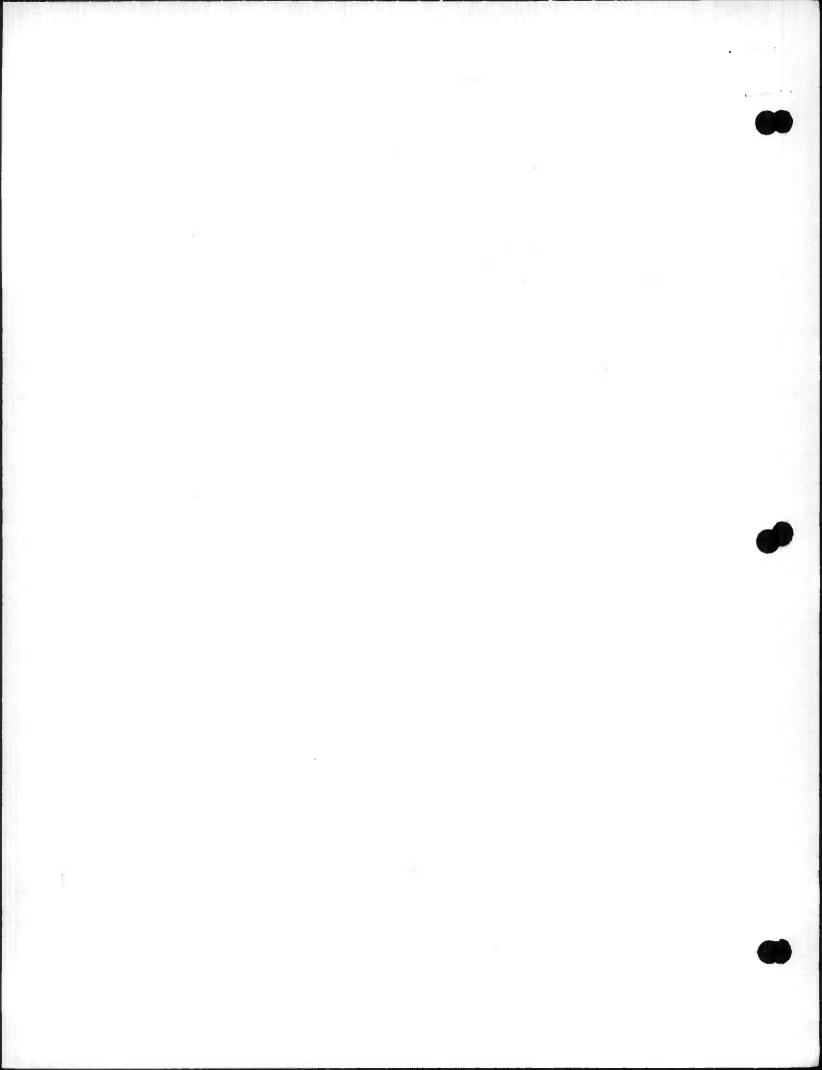
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICUS

	1 - STATE REGISTRAR		02 01		CERT	IFI	CATE OF	DEA	TH	WEN IN	REG. NO.	E		
	1. DECEDENT'S NAME (First,	, Middle, La:	st)							2. DATE	OF DEATH			3. TIME OF DEATH
	LILLIAN	LOUI	ISE KIN	SEY						Tim	e 23,	1998	YEAR	11:02 PM
	4. SOCIAL SECURITY NUMB	BER	5. SEX	6. AGE	(In yrs. last birtho	lay)	IF UNDER 1 YEAR	IF UNDE	R 24 HRS.	7 DATE	OF BIRTH		8. BIRTH	IPLACE (State or Foreign
	215–26–1717		1 🗌 M 2 🔯 F	68	YR	YRS. MONTHS			MIN.	March 27,		1930 Mars		vland
	9e. FACILITY NAME (If not in	stitution, giv	ve street and number)			\dashv	9b. CITY, TOWN	OR LOCATI	ION OF DI				NTY OF D	4
SR.	1813 Winsto	on Dr	ive			Hagers	town					hingt		
DIRECTOR	RESIDENCE OF DEC	EDENT				_	Tadgets	COWII				wasi	шид	JOH
R	10a. STATE	10b. COU					TOWN OR LOCA	200						10d. INSIDE CITY
	Maryland	Was	hington		F	lag	erstown							1 YES 2 1 NO
₹¥	10e. STREET AND NUMBER						10	ZIP COD				10g. CIT	IZEN OF V	VHAT COUNTRY?
FUNERAL	1813 Winsto	on Dr	ive					217	40			U.	S.A.	
ᆵ	11. MARITAL STATUS 1 Never Merried 2 🔀	Montad	12. WAS DECED FORCES?	ENT EVER	IN U.S. ARMED		13. WAS DEC	ENDENT (OF HISPAN	VIC ORIGI	N? (Specify Yes Ricen, etc.)	or No-	14. RACE	- American Indian,
B	3 Widowed 4 Divo		IF YES, GIVE					2 NO			1110011, 410.)		Speci	White
	15. DEC	EDENT'S E	DUCATION		ta, pecepe	CT10 L								MITTE
COMPLETED	(Specify only	y highest gri	ede completed)		(Give kind	f of wo	SUAL OCCUPATION done during mo	on of worki	ng	16	b. KIND OF BUS	SINESS/IN	DUSTRY	
2	Elementary/Secondary (0	1-12)	College (1-4 or	5+)			erator			- In	eakuva	unt_	Post	aurant
8	17. FATHER'S NAME (First, MI	idda Last)			7	- [-	024602	40. 1407	LAPPIN NA				Mest	aurant
	Max Frederi		lol fe								Middle, Malden		10	
BE	19e. INFORMANT'S NAME (7)		OIIC		10h MAII	INC 1	ODRESS (Street of				zabeth			
2	Leon G. Kins		Hughand											04740
	20e. METHOD OF DISPOSITI		nusband	201			WINSTON (NA		ve ,	Hage			City or To	21740
	1 Suriel 2 Cremetlo 4 Donation 5 Other	n 3 🗆 Re	emoval from State	CBI	metery, cremetory	or other	er place)		0'	1				
	21. SIGNATURE OF FUNERAL		LICENSEE	- IR	ose_Hil	1.0	Cemeter	V JUI	ne z	/ ; 19	98] Had	gerst	cown,	Maryland
	Douglas A. Fiery Funeral Home 21742													
	1/ //2011	May >	V F1	M	1331 Eastern Blvd. N. Hage:								stown	,Maryland
	23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart fellure. List only one couse on each line. Approximate interval Between													
	Interval IMMEDIATE CAUSE (Final Onset s													Onset and Death
	disease or condition resulting in death)	→		C-C	ww	~	201	u	m	5				18 month
ŀ			DUE 1	O (OR AS	A CONSEQUENC	E OF):			-	3				
S I	Sequentially list conditi	ions,	b											
Ě	If any, leading to immed cause. Enter UNDERLY!	diete	DUE	OR AS	A CONSEQUENC	E OF):								
CERTIFICATION	CAUSE (Disease or Injur		c	O (OR AS	A CONSEQUENC	E OEN								
Ē	that initiated events resulting in death) LAST	т				017.								i
8			_ d											-
DICAL	PART II. Other significan	nt conditi	ons contributing	to death b	but not resulti	ng In	the Underlyin	cause	given in	Part I.	24s, WAS AN . PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
잃											1 TENFOR			COMPLETION OF CAUSE
ME														OF DEATH? 1 YES 2 NO
	DID TOBACCO US	SE CON	ITRIBUTE TO C	AUSE C	OF DEATH	YES	NO [UNC	ERTAIN	v 🗆				
N N	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL			26. PLACE OF I	EATH	(Check only one)							
PHYSICIAN:	1 TES 2 THO		HOSPITAL:	☐ ER/Oul	patient 3 🗆 DO		OTHER: I Nursing Hom	5 A	esidence	6 🗆 Othe	er (Specify)			
된	27. MANNER OF DEATH		26e. DATE (Day, Year)	26b.	TIME		URY AT		26d. DE	SCRIBE HOW IN	NJURY OC	CURED	
B		Pending Investigation		,				ES 2] NO					
	3 Suicide 6 0	Could not b	bulldin	OF INJURY	Y — At home, far	m, str	eet, factory, offic			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
	4 Homicide	determined							_ 1	Ony	Or IDWIL State)			
COMPLET	29e. CERTIFIER 1 CERTI	IFYING PHY	YSICIAN: To the best	of my know	viedge, death occ	urred	at the lime, date	and place	, end due	to the ca	use(e) and men	ner ee atal	led,	
5	2 MEDIC	CAL EXAM	INER: On the basis of	examinatio	on end/or investig	ation,	In my opinion, d	eath occur	red at the	Ilme, date	end place, and	d due to th	ne cause(e)	end manner ee stated.
	296. BIGNATURE AND TITLE													
BE	tralen.	1	1 /	1	hΔ			A PC. LICI	ENSE NUN	יין א	,	Zyd, DAT	SIGNED	(Month, Day, Year)
2/	MANUEL AND ADDRESS OF	PERSON Y	WHO COMPLETED CA	USE OF DE	EATH (ITEM 27) (1	ivne p	Print1	N	4)(رار			U	1170
TOOCTU I HAS ILI MA 11110 Wed and Completed Cause of Death (ITEM 27) (Type, Print)									1-a -A+14	D.	1 11	maniher.		
	31. DATE FILED (Morth, Play 1	Marin 10	00 32. REGIST	AR'S SIGN	ATURE	1		v -Ca	~~	~~	mu	· ce	1	a 1 1000
	2014	W 7 13	1301 4	Mia Ja	a line	. 1	0.0							mary land



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) MARY ELIZABETH KENDALL 0110 JUNE 21 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. Sept. 29, 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Months 1□ M 25 F 1933 Maryland 220-28-3698 64 Yrs. Usuai Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Washington Hagerstown 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 16913 Pickwick Lane 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Defes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Sfafus Black, While, etc. 1 Never Merried Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) County Hospital Registered Nurse 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) William Lawrence Marpel Edna Josephine Hovermill 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) George L. Kendall, Husband 16913 Pickwick Lane, Hagerstown, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Cedar Lawn Memorial Park June 24 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Part. Enfer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 Approximate interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of) Un Known oregin Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Lest Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 💥 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpalient 2 □ ER/Outpatient 3 □ DOA 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. tnjury at Work? 1 MNatural 5 Pending

Physician /Medical Examiner

Department of Important: If any Injury or = 0

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

"naturel", or items 23s or adical Examiner must be

r than 'nature

7 le marked other traumatic event,

Peges 1 end 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
nt: If Item 27 Is marked other than "naturel", or Items 23

Baltimore, Maryland 21215-0020

the Maryland

Examiner Physician/Medical p Completed Be

physician and the burial-transit signed by the a d be detached t should I certificate hes t lirector, page 2 s To this funeral Certification:

that the death certificate be executed Division of Vital Records, P.O. Box 68760, law. or Attending Physicien: death. after deatl Director: à To the Hospital or within 24 hours aft To the Funeral DI completely filled in

> State Registrar

edical

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Nama and address of person who comple WUN KANG,

investigation

6 Could not be determined

JUN 2 2

2 Accident

4 Homicide

29b. Signature end fitle of certifier

31. Dete filed (Month, Dey,

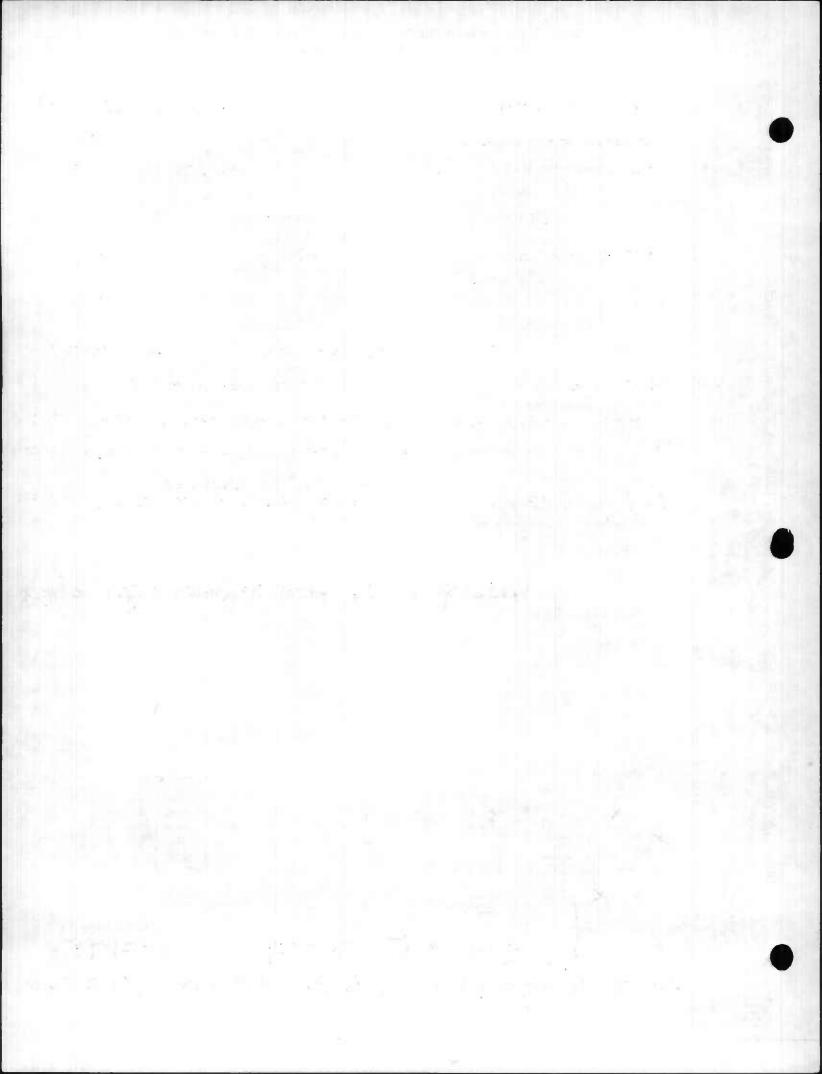
3 Suicide

29a. Certifier (Check only one)

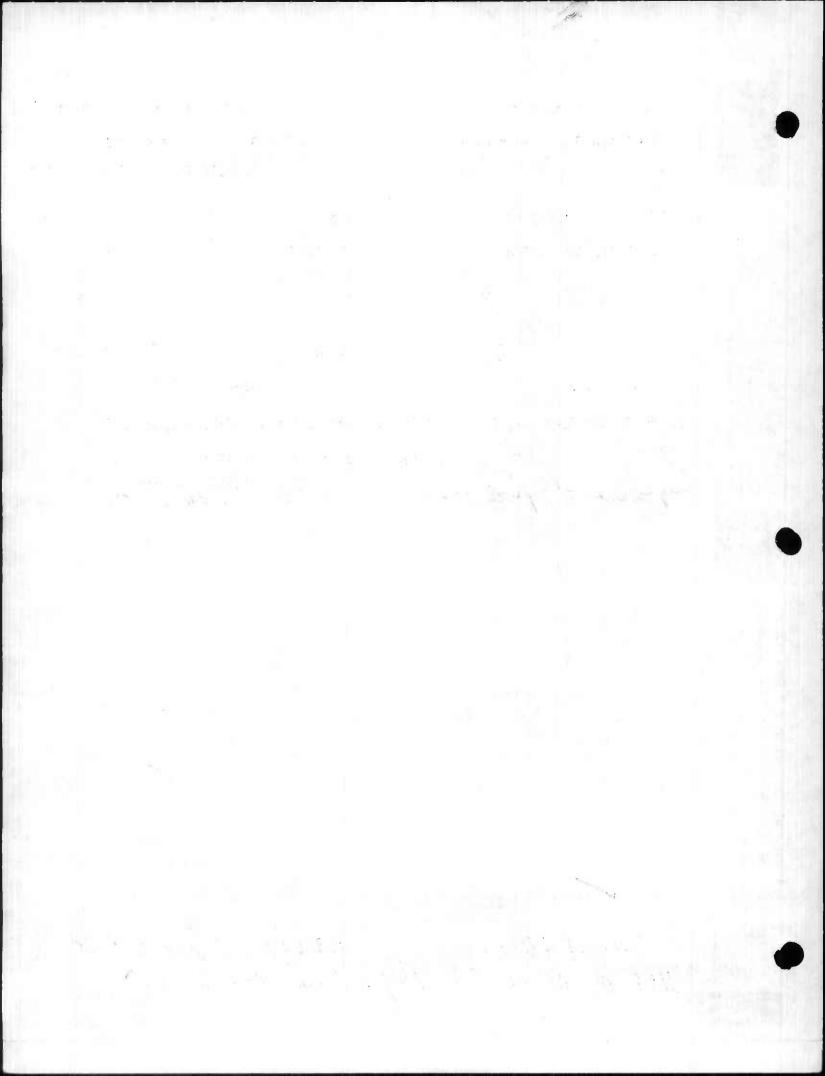
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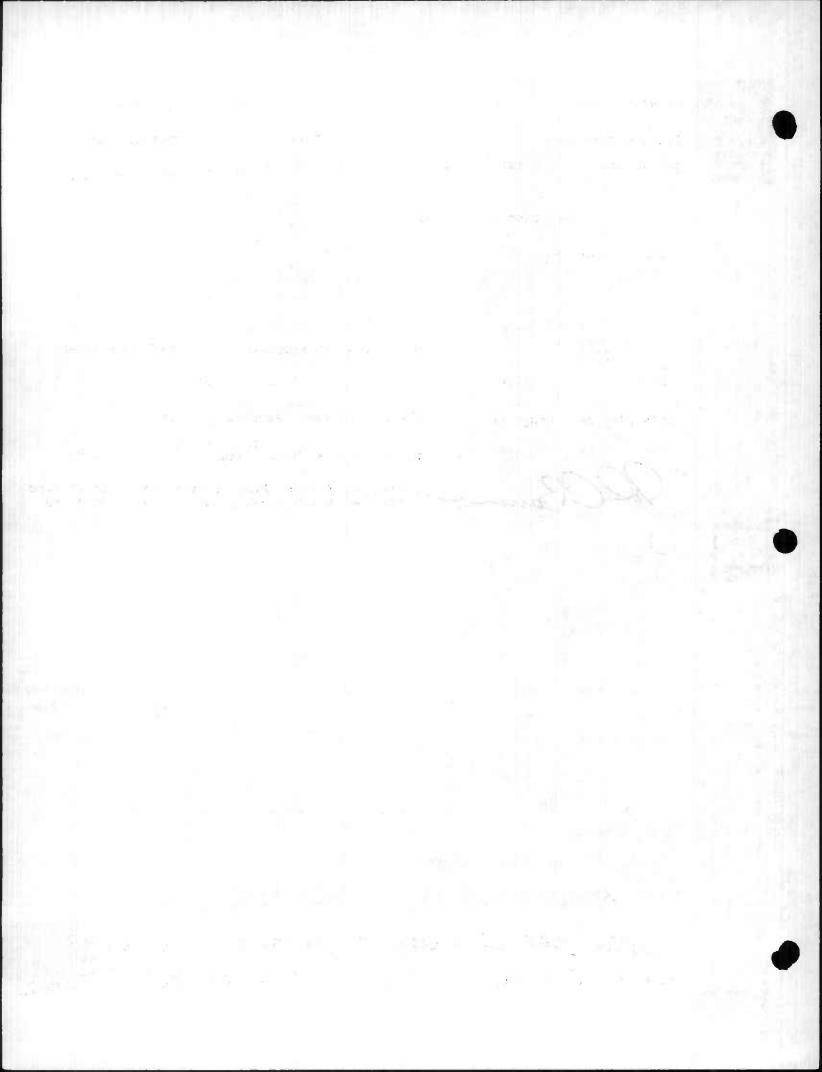


iclan			С	erinicate of	Death	R	eg. No.	2 4 5
	1. Decedent's Name (First, Middle, Le Samuel Rober	,				2. Date of Dee Month	Dev	Yeer 3. Time of D
dical niner	4e. Fecility Neme (If not institution, giv				4b. City, Town, or L		3, 1998 4c. County	
	RAVENWOOD LUTH				HAGERST			INGTON
at or		7. Age (In yrs	s. lest birthda Yrs.	Months Dave		8. Date of Birth Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	Y991	9. Birthplece (State or F New York C
ctor	Usual Residence of Decadent 10a. State 10b. County Md. Wash	ington 10c. C	City, Town or	Location miths burg	***			10d. Inside City
al Director	10e. Street end Number 11808 St. Mary	's Court		10f. Zip Code	21783	1	0g. Citizen of V	Vhat Country? I.S.A
by Funeral	11. Marital Status 1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates:	U,S. 1:	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No		ecify Yes or No- Rican, etc.)		e - American Indian, kk, White, etc. : White
Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondary (0-12)		16e. De (Gi life	cedent's Usual Occu ive kind of work done o. DO NOT use retire Supervi		ing	16b. Kind of Bu	isiness/industry L Governmen
To Be Co	17. Fether's Name (First, Middle, Last) USher Katz				18. Mother's Nem	e (First, Middle, I annah Go	Melden Sumam	
-	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Stree	t end Number or Rui	el Route Number	City or Town,	Stete, Zip Code)
	Maude Eccard Ken 20e. Method of Disposition 1 M Buriel 2 Cremetion 3 Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control	Removal trans State	Pleca of Dis	8 St. Mar sposition (Neme of remetory or other ple banon Cem	ice)	Dete	20c. Location -	City or Town, State
200	21. Signature of Fund of Service Lices	-		22. Name and Addr Davis Fun	ess of Facility	12525 B	radburu	Ave.
n d	23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	olic tions that caused the deader one cause on each line.	ath. Do not e	enter the mode of dyi	ng, such es cardiac	or respiretory erro	est,	Approximate Intervel Betwee Onset end Dea
	resulting in death)	Due to	(or es a cons	sequence of):				
Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying	b. — Due to ((or as e cons	sequenca of):				
Physician/Medical	Cause (Diseese or Injury that initiated events resulting in death) Lest	c Due to (or es e cons	equence of):				
	Part II. Other significant conditions or	0	sulting in the	2	ven in Part I.		bacco use con	atribute to the cause of o
	Essenti						n autono.	24b. Were autopsy find
þ	Esseuli	/,				24a. Was a perform		eveileble prior to completion of cause of deeth?
Completed by		,					ned?	completion of caus
Be Completed by	25. Wes case referred to medical exeminer?	Hospitel:	TEP/Outpot	See all DOA Ott	26. Piece of Deet	perform 1 Ye	es 2 No	completion of causof death?
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edical Certification: To Be Completed by	25. Wes case referred to medical exeminer? 1	28a. Date of Injury (Month, Dey Year) 28a. Plece of Injury - At h	28b. Time Injury home, farm, s ify)	of 28c. Inju // M 1 1 street, fectory, office	A Nursing Horry et rk? Yes 2 No	h (Check only on me 5 Reside 28d. Describe ho	es 2 No e) ence 6 Other ow injury occurre reet and Number, Stere)	completion of cause of deeth? 1
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State of Maryland / Department of Health and Mental Hygiene (1997)

							Certifica		Death	F	Reg. No.	1	1410
Phys	ician	1. Decedent's Name (First, Frances Le	^{viiddle,} La ona	Kone						2. Date of Dea Month	Day	Year	3. Time of Death 11:55 am
/Me	dical				-1				th Oh T	June	14,	1998	11:55 am
Exan	niner	4a. Facility Name (If not inst Genesis Elde			r)				4b. City, Town, or I Severna			ty of Death Arunde	. 7
_e Funera	ai	5. Social Security Number	6. 8	Sex 7. A	ge (In yrs. I	ast birth	If Und Month	ler 1 Yaar s Days		- 072.11			lace (Steta or Foreign try)
Directo	ME.	505-26-9956 Usual Residence of Decede		1 □ M 20XF	76	Υ	rs.	Days	Hours Mill.	Oct 8,	1921		rado
A Mand		10a. Stata 10b. Co			10c. City	, Town	or Location					10	Od. inside City Limits
e Man	ctor	MD A	nne	Arundel	Ar	nol	i						1 ☐ Yes 2 ☑ No
ter death with the Marylar items 23e or 28e-f show ner must be notified at	Director	10e. Street and Number					10f. 2	ip Code			10g. Citizen o		try?
na 25a mark	Funeral	488 Eleano	r Lar	1e 12. Was Decaden	t Ever In 111		12 Mac Do	2101			14 0	USA	and adlay
-0020 hours after d turel, or then at Examiner.	þ	1 Never Married 2 3 Widowed 4 Divo		Armed Forces 1 Yes 25 If Yes, Give Year or Detes	? [No	o.			dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, atc.)	Spec	aca - Amarica ack, White, e hity: Wh	
72 hg	eted	15. Dec (Specify only h	adant's Ed	ducation ade completed)		16e. [Decadent's Us Give kind of	ual Occup	pation during most of wor d)	king	16b. Kind of	Business/Ind	ustry
within one. than	Completed	Elementary/Secondary (0-	12)	College (1-4or	5+)				d) Accountar		Food	Whole	saler
Dd Hyg	Be Co	17. Father's Neme (First, Mid	ddle, Lest,							ne (First, Middle,	Meiden Surne	eme)	
ylan Mental Mental Mental Mental Mental Mental Mental Mental	ToB	Henry		Pilant					Alice	Sh	rup		
, Maryland 21215-0020 and 2 should be fled within 72 hours at selfs and Mental Hygene. 127 is marked other than "natural", or or traument event, the Medical Examp		19e. Informant's Neme/Rela Wanda Edward							and Number or Ru ane, Arn			n, Stata, Zip	Code)
Baltimore, semil: Pages 1 a begartment of Heam moortant: If Item my Injury or othe		20a. Method of Disposition 1 DXBurial 2 □ Crema 4 □ Donation 5 □ Oth			CE	m atary	Disposition (A cremetory of even Me	other pla	al Park	June 18	Glen I		
Salt semil sport my inh	ilea in	21. Signature of Juneral Ser	victo Ligar	900					ess of Fecility	A C	D	ala E	-m-1 Henr
m 0054	2	YOU	112	ann	9	-	495 G	v. R	itchie Hy	v. Sev	erna Pa		eral Home D 21146
Dhualala		23a. Part. Enter the diseas shock, or heart feilure.	e, or com List only	plications thet cause one ceuse on eech	ed the death line.	. Do no	at enter the m	ode of dyle	ng, such as cardiac	or respiratory are	rest,		Approximate Interval Batween Onsat and Deeth
Physician /Medica	1	Immediate Cause (Finel disaese or condition		500	cic								
Examine		resulting in death)		a. 3()	Due to (or	as a co	nsequence o	f):				1	
De isi	nine			b. (1)	Sect	- 4	200	<	zang	ren	2		
68760, tificete be executed ig physician and as the bunel-transit	Examiner	Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Cause (Disease or Injury		0.0	Due to (or	as a co	nsequence o): (v di	1		
68760, ficete be ex physician is the buriel	edicai	Cause (Disease or Injury that Initiated events rasulting in death) Last	4	c. per	Due to (or	as a co	nsequance of):	and.	V OH	seas	2	
2 0 8	-	rasuling in dealin) Last	L	· dio	Col	fe	2	me	elliti	us			
. 5 0 2	Physician/	Part II. Other significant con	ditions o	ontributing to death	but not resu	Iting In t	he underlying	cause giv	en in Part I.	23b. Did to	obacco use c	ontribute to	the cause of death?
P.O. hat the de de de deteched	Phy	conpati.	19	heard	+ fe	21	LIVE			1 🗆 Y	08 20 No	3 Prob	ably 4 Unknown
Division of Vital Records, P.O for Attending Physician: The law requires that the after death. Director: After this certificate has been signed by the funeral director, page 2 should be deteched in by the funeral director, page 2.	sted by	atrial	GL	villa	Kin		h	ist		24e. Was a	in autopsy med?	ava	re eutopsy findings
Rec The law	Completed	of entro	inte	o stina	0 6	10	o di	0		. 1 Y	es 2 No	of d	npletion of cause leeth?
/ita	Be	25 Was casa referred to me exeminer?	dical				(1	26. Piece of Dea	th (Check only or	10)		
Of Physic this contained in	10	1 ☐ Yes 2 No 27. Manner of Death		Hospital:			atient 3 [4 K Nursing H	ome 5 Raside)
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or Attender dealine by the	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be termined	28e. Place of In	ijury - At hor tc. (Specify)	ne, farm	n, street, facto			28f. Location (Si City or Town	treet and Num n, Stete)	ber or Rural	Route Number,
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29e. Certifier	Ifying Phy	ysician: To the best	of my know	ledge, d	leath occurre	d at the tir	ne, date and place,	and due to the c	euse(s) and n	nanner as sta	ited.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Dete of Death

1. Decedent's Name (First, Middle, Lest) **Physician** Month Kiefer 27, 1998 /Medicai June Grace Ann
4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** alisbury Center; Genesis ElderCare Salisbury, Md W If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Yeer) Wicomico If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 25 F Yrs Director 214-34-5422 83 January 14, 1915 Maryland Usual Residence of Decedent tha Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Exerciper must be notified at Director Maryland Wicomico Salisbury 10e. Street end Number 10f, Zip Code 10a. Citizen of Whet Country? 804 Brown Street 21804 USA deeth Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baitimore, Maryland 21215-0020 1 Yes 2X No Specify: g Specify 3X Widowed 4 ☐ Divorcad "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7: and Mental Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Domestic 8 permit. Pagas 1 and 2 should be file Departmant of Haalth end Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Albert G. Stephens Viola Baker 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Betty J. Stephens/Sister 30562 Bennett Rd., Salisbury, MD 21801 f Disposition (Neme of Date 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) Wicomico Memorial Park 7/1/98 Salisbury, MD 21. Signature of Funeral Service Licer 22. Name end Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease or complication, that cause of the doubt. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each one. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Neumon **Examiner** Examiner bunial-transit

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting In deeth) Last Physician/Medical

Due to (or as a consequence of)

Approximate Interval Between Onset and Deeth

3. Time of Deeth

3:20 PM

10d. Inside City Limits

White

1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Dete of Injury (Month, Dev Year)

MID

1 Inpatient 2 ER/Outpetient 3 DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

the Devoler Redall

28b. Time of

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 26. Plece of Deeth (Check only one)

Other: Nursing Home 5 Residence 6 Other (Specify)

28d. Describa how Injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of cartifier

5 Pending

investigation 6 Could not ba determined

29c. License number 298 (3

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

M ATKI'NS 31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

Natural

3 ☐ Sulcide

29a. Certifier

2 Accident

4 | Homicide

1104 HEALTHWAY DR., SALISBURY, MD 21804

28c. Injury at Work?

Registrar

JUN 3 0 1998

DHMH 16 Rev 6/95

P.O. Box 68760,

Records.

Division of Vital

attending physician for usa as tha buria

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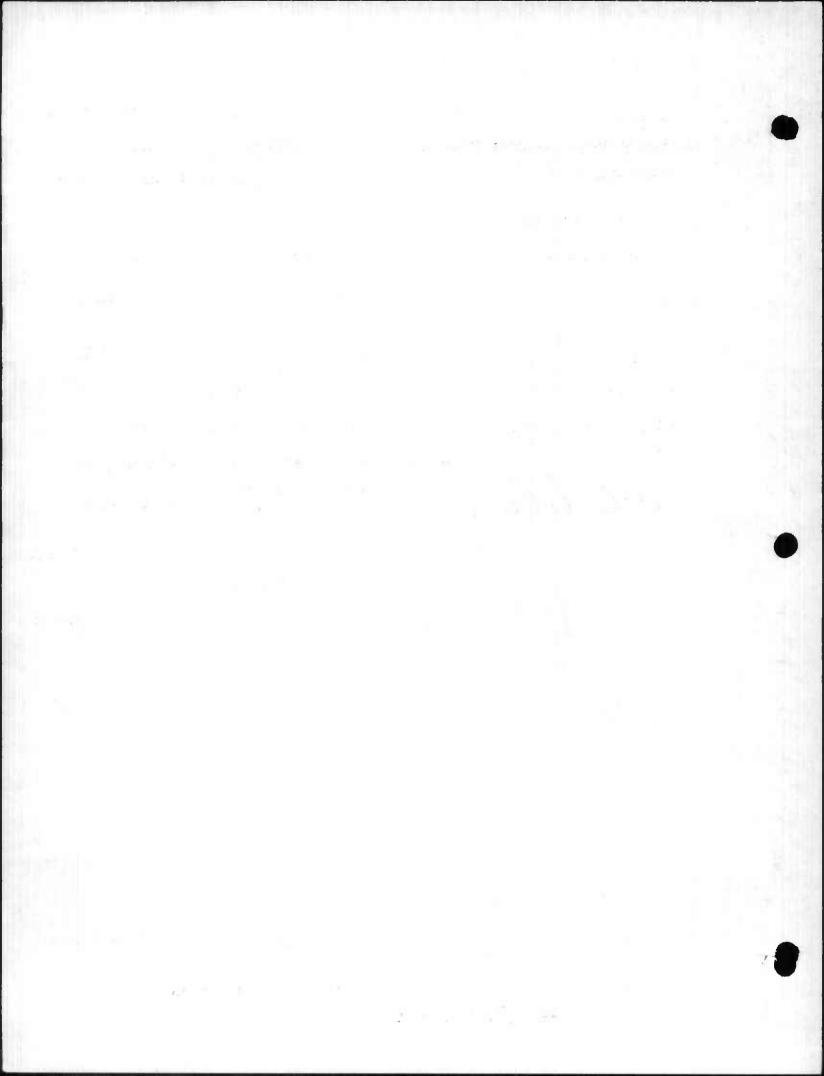
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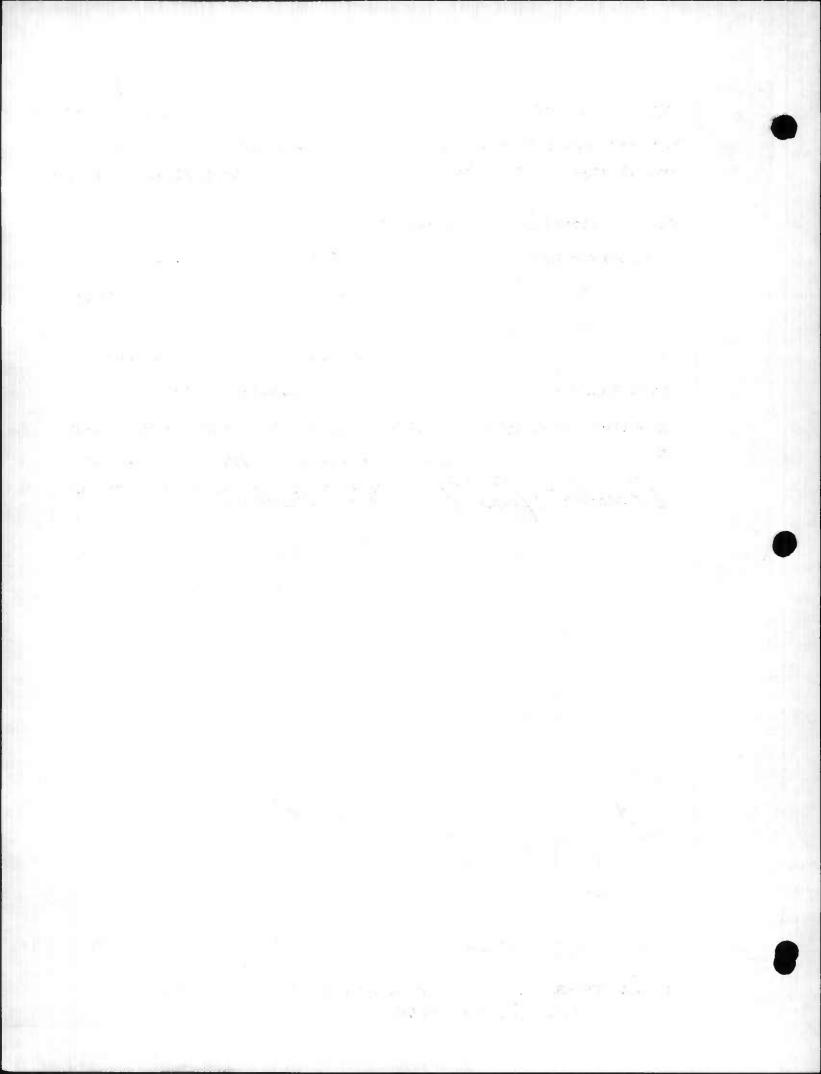
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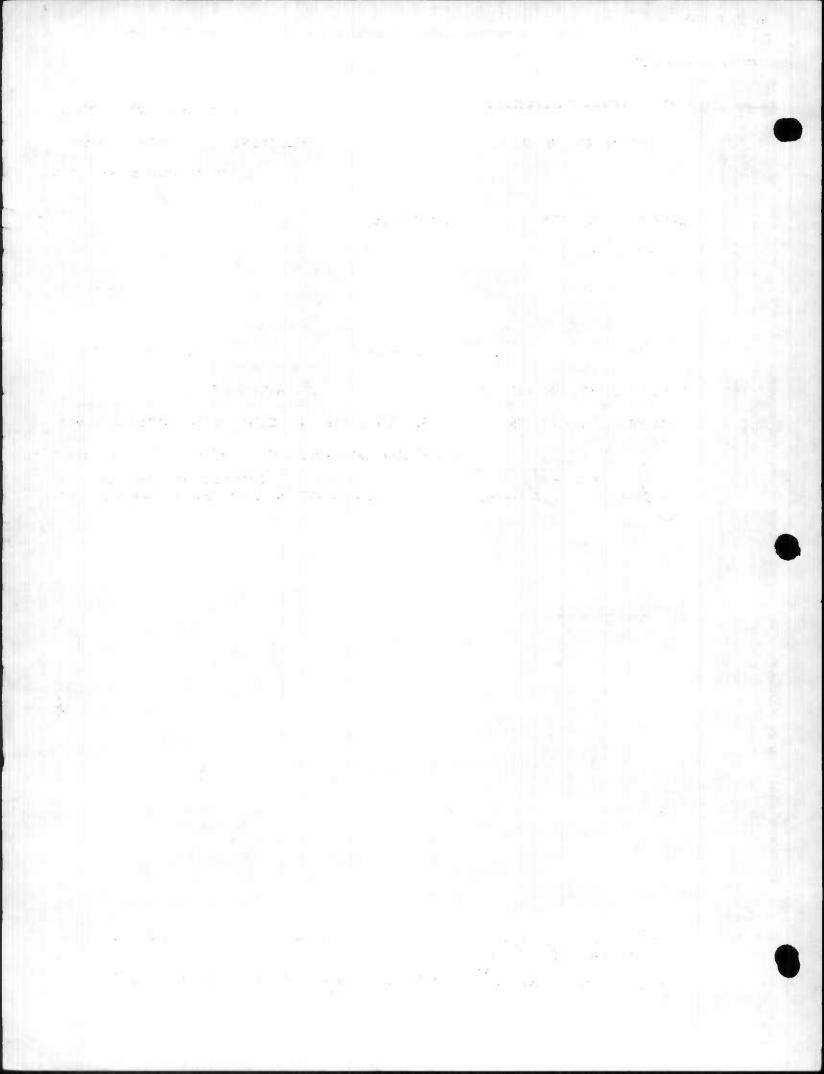
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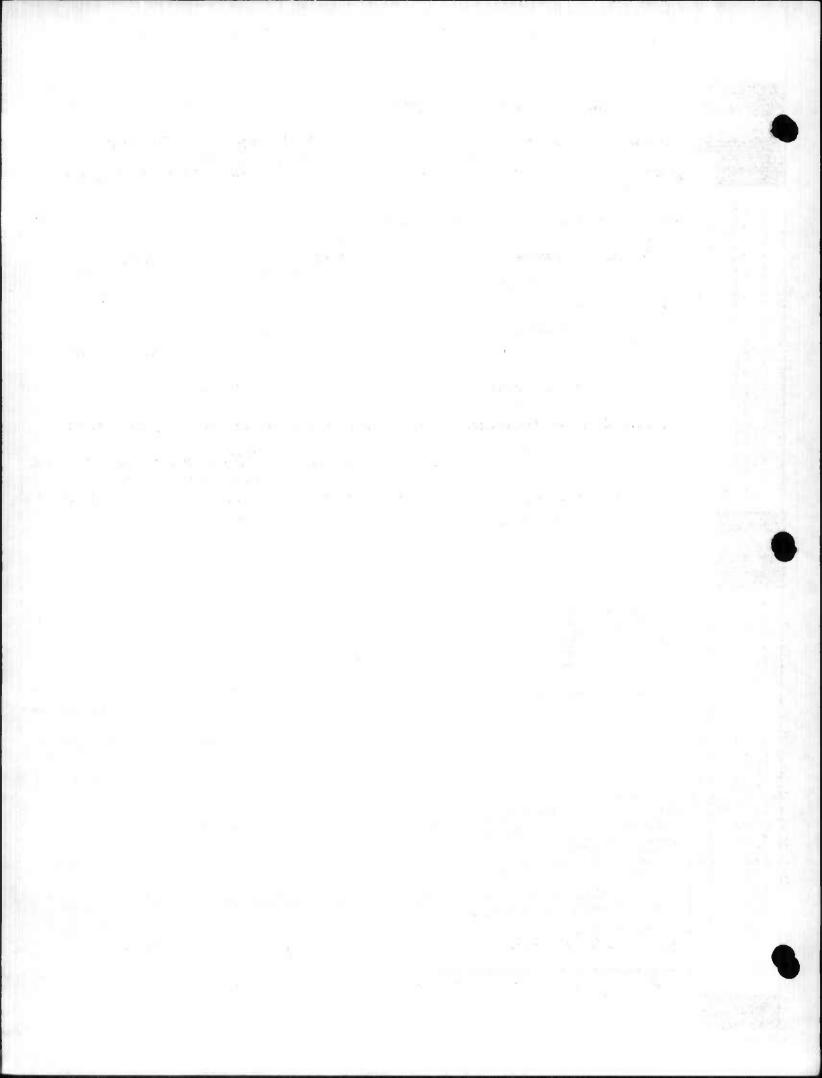
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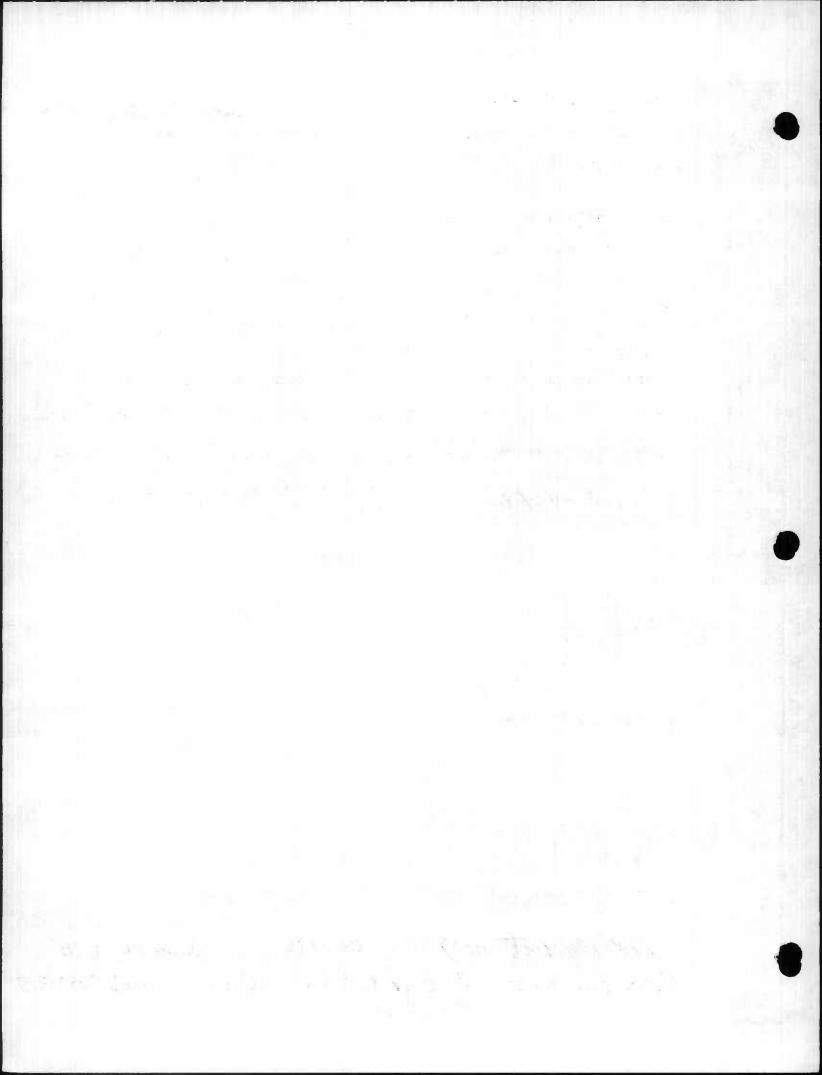
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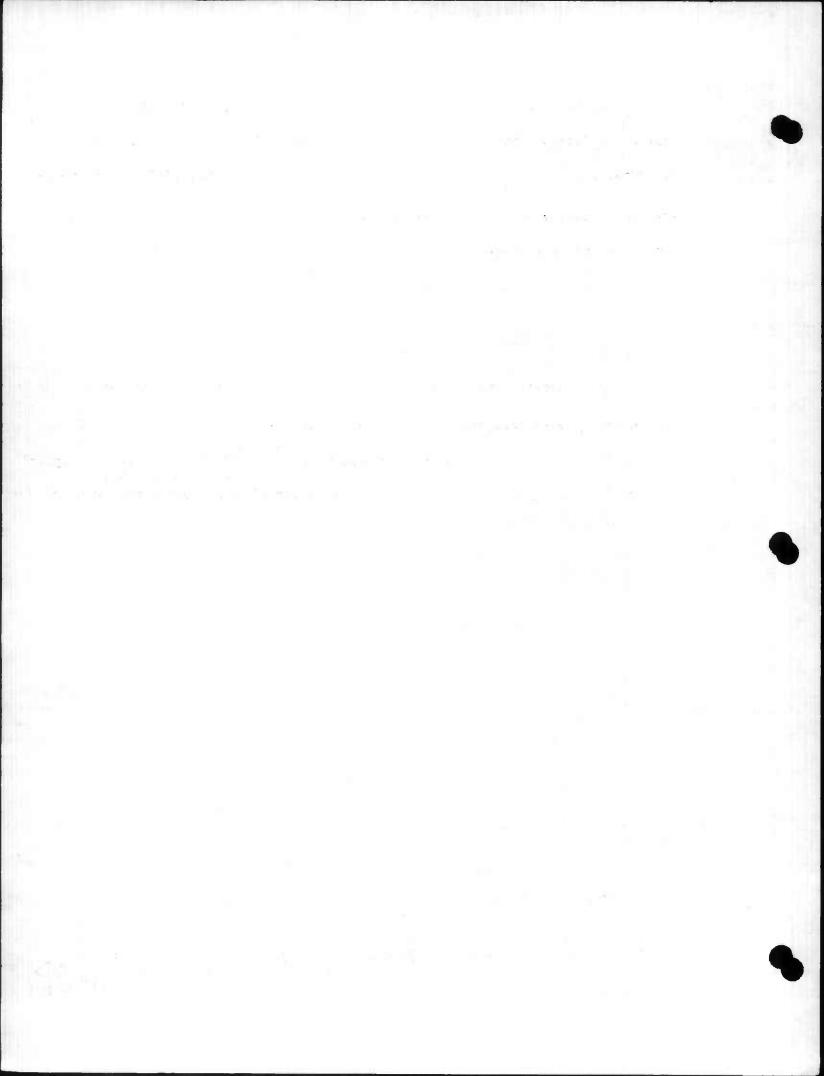
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25. Wes case referred to medical exeminer? 1	seen s	וואופנפת מ	1								ava	ilable prior to apletion of cause
27. Manner of Death Natural S Pending Investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b.	r, pa		nc 111						10	Yes 2 No	1 🗆	Yes 2 No
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101601 1	s effe	-	29e. Certifier 17 Certifying Phy	alclan: To the best of	exemination an	, death oc d/or invest	curred at the tim igetion, in my o	ne, date and place pinion, deeth occu	e, and due to the urred et the time,	cause(s) and me date and plece, e	nner as stand due to	sted.
A A A A A A A A A A A A A A A A A A A	24 hours efte Funeral Dire etely filled in dical Certl		Check only 2 Medical Exam	and manner state	ed.							tile cause(s)
30. Name and eddress of person who completed cause of death (Item 23a) (Type Print)	vithin 24 hours effective to the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of the Funeral Certification of th	-	one) 2 Medical Exam	and manner state	ed.		29c. License	e number		29d. Date signed	(Month, L	
	within 24 hours efter To the Funeral Dirac completely filled in I Medical Certi	-	one) 2 Medical Exam	and manner state	ed.					1		Day, Year)



State of Maryland / Department of Health and Mental Hygiene

				Otato of Ma	il ylullu	Certific		Death		eg. No.	2	1423
	Physic	an	Decedant's Nama (First, Middla, Last)		IIID A				2. Data of Dea Month		Yaar	3. Tima of Death
	/Medi	cal	Jo Ann		ZERS				June 1	9, 1998	3	8:20 p.n
7	Examir	ner	4a. Facility Nama (If not institution, giva s 751 South Potomac					4b. City, Town, or Hagerst		4c. County	of Death	on.
-	Funeral		Social Security Number 6. Sax	7. Aga	(In yrs. last		dar 1 Yaar	if Under 24 Hrs	8. Data of Birth			laca (State or Foreign try)
В	Director		213-40-3170	M 281F	56	Yrs. Monti	hs Days	Hours Min.	May 27,			sylvania
	and and		Usual Rasidance of Decedant 10a. Stata 10b. County		10c. City, T	own or Location					10	0d. insida City Limits
	Mary	tor	Maryland Washingt	ton	H	lagerstov	√n					1XONyas 2 □ No
	or 284	Director	10e. Street and Number			10f.	Zip Code		1	0g. Citizen of V	What Coun	try?
	eth w		751 South Potomac					21740			S.A.	
020	within 72 hours efter deeth with the Maryland ilene. Then "natural", or flems 23s or 28s-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant E Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas:				Hispanic Origin? (Spen, Maxican, Puan Specify:	Specify Yas or No- to Ricen, atc.)		e - Amarica ck, Whita, a c: Wh	
21215-0020	within 72 ho ene. then "natur re Medical	Completed	15. Decedant's Educ (Specify only highast grade Elementary/Secondary (0-12)	cetion a complated) Collega (1-4or 5-	1	6a. Decedant's U (Giva kind of lifa. DO NO	sual Occu work dona Tusa ratire	pation during most of wo	rking	16b. Kind of Bu	usinass/Ind	ustry
	filed within Hygiene. Ither than	Com	0-10	O	'	daycar	e pr	ovider		dayca	are	
Maryland	d is b >	Be	17. Fathar's Nema (First, Middla, Last)	lie Beaver	. C.			18. Mothar's Na	ma (First, Middla, I		,	
Ž	2 should bend Mentale marked	70	19e. Informant's Neme/Raletionship (Ty):			ISh Mailing Addr	acc (Straa	t and Number or Ri		Ruth Ha		
	1 and 2 a Health er em 27 la other trau		Mrs. Kimberly Dree		-			Avenue,				
Baltimore,	es 1 and of Health I Item 27 r other tr		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Re			of Disposition (fatary, crematory of	Nama of or other pla	ice)	Data	20c. Location -		
ţim	. Peges iment of I bant: If Ite jury or or		4 ☐ Donation 5 ☐ Othar (Specify)		Ceda	ar Lawn M	1emor:	ial Park				, Maryland
Bal	permit. Peges 1 and 2 should Depertment of Health end Mer Important: If Nem 27 la marke any Injury or other traumatic once.		21. Signatura of Funaral Sarvice License	Maria	10				Minnich I lvd., Hag			ryland 217
			23a. Pert1. Entar tha disaase, or complice shock, or haart failura. List only on	cations that ceused to a causa on each line	ha daath. D	Do not antar the m	node of dyl	ng, such as cerdia	c or raspiratory arr	est,		Approximate Intarval Between
	Physician /Medical Examiner		Immediata Cause (Finel disaasa or condition rasulting in daath) a	An	Oua to (or as	a consequence	M OL	l C	dma	U.		Onset and Death 3 Years
	tificete be asscuted by physician and as the burial-transit	edical Examiner	Sequentially list conditions,)D	ua to (or as	a consequance	of):					
68760,	siclan buria	calE	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avants		and the latest							
Box 68	E 0 8		resulting in death) Last		ua to (or as	a consequance o	or):					
Ö.	0 0 0	Physician/N	Part II. Other significant conditions cont	tributing to death but	not rasultin	g in the underlyin	g ceusa gir	van in Part I.	23b. Did to	pacco hae co	ntribute to	the cause of death?
s, P.O.	requires that the death cer ween signed by the ettendir hould be detached for use	by Phy							1 □ Y	2 No	3 Prob	ebly 4 Unknown
Vital Records,	requir sen s hould	Completed I							24a. Was a perform		con	ore autopsy findings uilable prior to inpletion of ceuse death?
<u> </u>	The law ate has b page 2 s	Com							1 🗆 Ye	s 2 No		Yas 2□ No
/ita	iclan: The certificate rector, pay	Be (25. Was cese rafarred to medicel axaminar?						eth (Check only on	a)		
ō	Physician: r this certific rral director,	. To	1 ☐ Yas 2 No	ospitel: 1 ☐ inpatian 28a. Data of Injury	-	Outpatient 3 D	DOA Oti		ioma 5 Rasida 28d. Describe ho)
O	Attending I or death. ector: After by the funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accidant invastigation	(Month, Day	Year)	Injury M	Wo	rk?]Yas 2□No	20d. Describe III	w injury occur	.60	
Division	2 4 2 5	Certification:	3 Suicida 6 Could not be datermined	28a. Place of injur building, atc.		, farm, straat, fact	tory, office		28f. Location (SI City or Town		er or Rural	Routa Number,
	Hospital 24 hours Funeral stely lilled	edical	29a. Cartifier Certifying Physic (Check only 2 Medical Examine	ar: On tha besis of a	xamination	iga, daath occurr and/or invastigati	ed at the ti	ma, dete and piace	, and dua to tha co	ausa(s) and ma ata and place,	nnar as sta and dua to	ated. tha cause(s)
	To the Hospital within 24 hours of To the Funeral completely lilled	Med	one) 29b. Signatura and titla of certifier	and mannar state	ed.		29c. Licans			9d. Data signe		
	F > F ŏ		De la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constante de la constant	Ha.			NI	11.7	3	6/2	2/0	18.
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	Sta Registr	_	31. Data filed (Monty Que 200998)	guille 10	da do de lure	Pandell			/			



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F	RANK M	ILL		riease	State of	Maryland	/ Depa	artment	of l	Health a					2	11,2	2
1	ASP Physic	ian	1. Decedent's Name	_		-i W211		rtificate	or O	Death		2. Date of De Month	Day		Yeer	3. Time of	5.5416.7
	* /Medi Exami	cal	4e Facility Name (If r			er)	ler,	Sr.				JUNE cation of Deet		County o		1343	P
	Funeral Director		WASHINGT 5. Social Security Nur 214-09-225 Usual Residence of D	mber 6. S 54		PITAL Age (in yrs. lest	birthday) Yrs.	If Under Months	1 Yeer Days			8. Date of Bir (Month, De Februa:	th y, Year)		9. Birthpl Coun 7 Ma	ace (Stete o lry) Iry1an	r Foreign d
	e Maryland la-f show offed at	ctor	10a. State	10b. County Washing	ton	10c. City, T		stown							10	0d. Inside Ci 1 ☐ Yes	
	23a or 28	ral Director	10e. Streef and Numb	oodhaven	Drive			10f. Zip		1742			10g. Citiz	S.A		try?	
020	72 hours after death with the Maryland natural", or items 23a or 28a-f show acel Examinet must be notified at	by Funeral	11. Maritel Status 1 Never Merriec 3 Widowed 4		12. Was Decede Armed Force 1 Styles 2 If Yes, Give Year or Date	es? □No WILITT		Was Decede If Yes, speci 1 ☐ Yes 2				ecify Yes or No Rican, etc.)		Black	- America White, whi		
21215-0020	within ene. than *	Completed		15. Decedent's Ed y only highest gre dary (0-12)			(Give	dent's Usue kind of wor DO NOT us ard	l Occu k done e retire	pation during mos d)	t of work	ing	p	riso		lustry Maryla	and
Maryland ;	should be filed and Mentel Hygies marked other umatic event, III	To Be C		Frank 1		er, Sr.						Selind	a Jol	hnso	n		
	1 and 2 lealth a Im 27 Is		19a. Informant's Nam Mrs. Cath 20a. Method of Dispo	erine V.	* * * * * * * * * * * * * * * * * * * *	wife	1922	-	lhav	ven Dr	rive,	Hagers Date	town,	Mai	ry1a		742
Baltimore,	Department of Important: If He any Injury or or once.		4 Donation 5	Cremation 3 Other (Specify) ~	ate	t Hav	ven Ce	emet	tery	2	une 3,1998 Minnic				Mary	land
Ba	Departm Departm Importa any Inju		21. Signature of Fund	ott!	Mer	nich				ess of Facility Wilson		/d., Ha					1 2174
	Physician /Medical Examiner	ner	23a. Pert1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in deeth)	inel	olications thet cau	ultyl	Do not ent	lyn	of dy	Ing, such as	cardiac	or respiratory a	rrest,			Approximation at Interval 6 at Onset and I	e ween Death
,092	be executed sician and burial-fransit	cal Examiner	Sequentially list conditions if any, leeding to immicause. Enter Underly Ceuse (Disease or in	ditions, nediate ying	b	Due to (or es	a consec	quence ot):									
Box 687	certificate iding physise as the	B	that initiated events resulting in death) La		d	Due to (or es	e conseq	quence of):									
s, P.O. B	that the death ned by the etten e detached for u	by Physician/M	Part II. Other aignifica	ant conditiona co	ontributing to deat	h but not resultin	g in the u	nderlying ca	use gi	iven in Part I	l.		tobacco	_	tribute to	the causa	of death? Unknown
Records	e law requires that been signified be	ompleted b											an autop ormed?	sy	CO	are autopsy nailable prior of or death?	0
Œ	he he age	0										W	Yes 2	□ No	11	Yes 2	No

Division of Vital To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifical completely lilled in by the funeral director, p Be Medical Certification: To

25. Wes case referred to medical examiner?
1 □ Yes 2 □ No

27. Manner of Death 5 Pending Investigation

8a. Dete of Injury (Month, Dey Year) 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28b. Time of Injury 1100

3€ DOA 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Plece of Death (Check only one)

29a. Certifier (Check only one)

1 Naturel
2 Accident
3 Suicide

4 - Homicide

Roadway 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end fitte of certifier

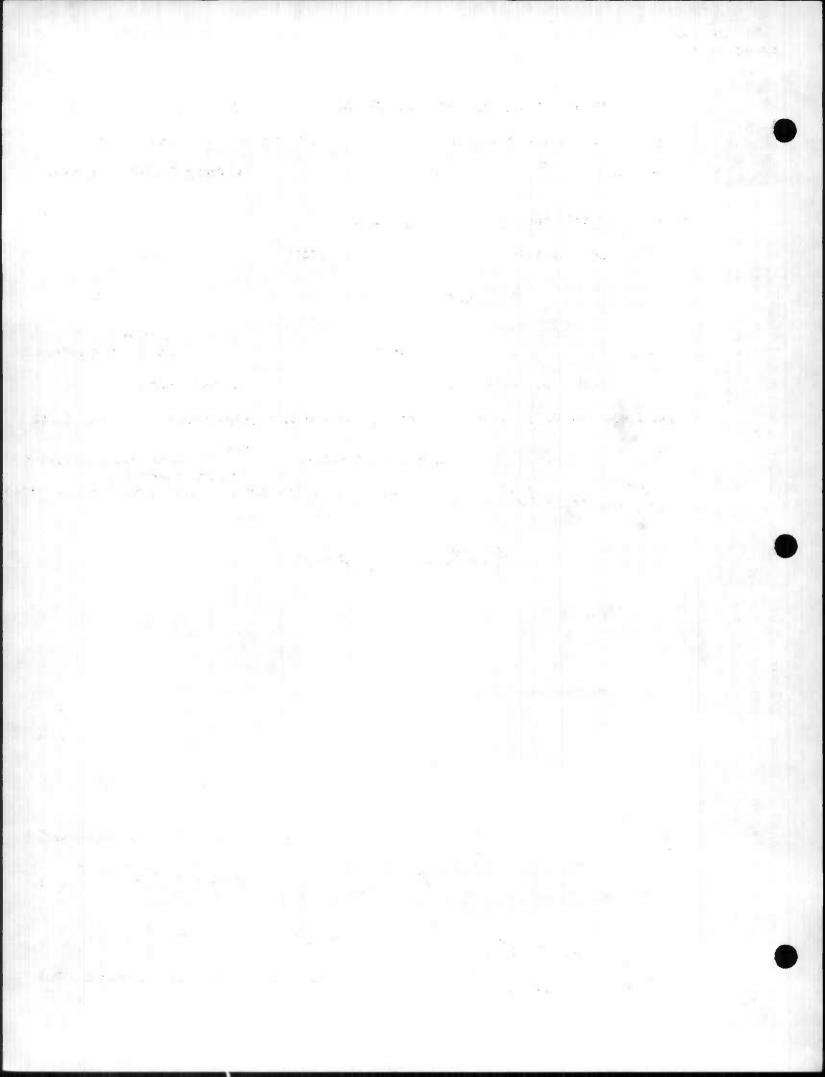
29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) JUNE 20,1998

30. Name and address of person who completed cause of heath (Item 23a) (Type, Print)

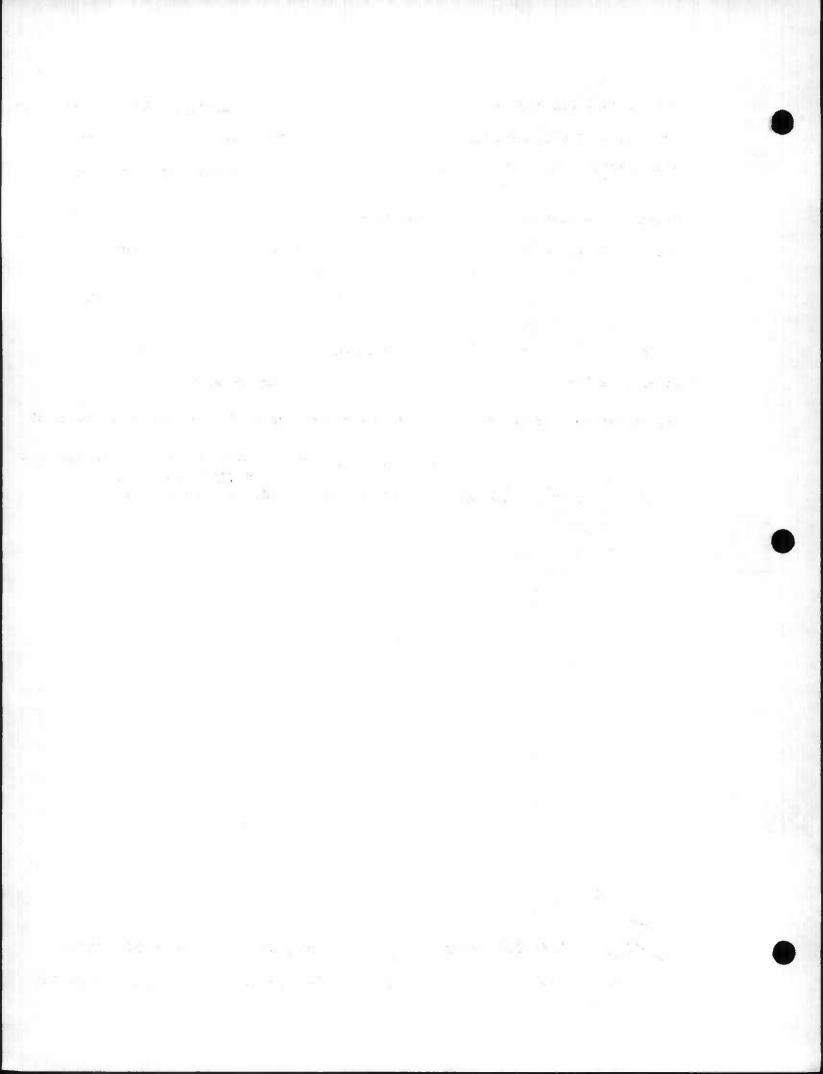
111 Penn Street, Baltimore, Maryland 21201

State Registrar



State of Maryland / Department of Health and Mental Hygiene

					•	Certif	ficate o	f Death		Reg. No.	1	146	14
	- Parlinder		1. Decadant's Neme (First, Middle, Las	st)					2. Date of De		Year	3. Time o	of Death
	Physici /Medi		Lottie Virginia	Mayhue					-	1998	Tear	052	24 a.m
	Examir		4a. Facility Name (If not Institution, give					4b. City, Town, or					
_			Washington Count					Hager			ashin	gton	
	Funeral Director		220-10-3109	ax 7. Aga □M 2⊠F	(In yrs. last bir 91		Under 1 Yes		. (Month, D	th ay, Year) 1,1907	9. Birthple Counti Mary	(Y)	or Foreign
	and war		Usual Residence of Decedent 10a. Stata 10b. County		10c. City, Tow	n or Locati	ion				10	d. Insida (Olty Limits
	Mary 4 sho	ō	Maryland Washing	ton	Ная	gerst	own						s 2 No
	the rott	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Count	ry?	
	N WIT	O	301 Brookline Ave	nue				21740		U	SA	•	
21215-0020	permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Give Year or Dates:				f Hispanic Origin? (Suban, Mexican, Puar o Specify:	Specify Yas or No to Rican, atc.)	14. Rac Biad Specify	e - Amarica k, White, a		
Ö	2 hot	be	15. Decedent's Ed	lucation	16a.	Decedent	's Usual Occ	upation	Saut -	16b. Kind of Bu	ısiness/indu	ustry	
215	hin 7	Completed	(Specify only highest gra Eiementary/Secondary (0-12)	de completed) College (1-4or 5-	e)	(Giva klnd	d of work dor NOT use reti	ne during most of wo ired)	orking				
	od wit	Corr	8	0	<u>'</u>	hous	ewife						
nd	be file d oth	Be	17. Father's Name (First, Middle, Last)							, Maiden Sumam	10)		
<u>Ş</u>	Men Men merke	2	James Sprankle						isa Wil				
Maryland	12 sh h and r is rr traum		19a. Informant's Name/Relationship (7			-		et and Number or R ise Churc					7/2
o,	Healt Healt em 2		Justin Mayhue - g 20a. Method of Disposition	Landson					Date	20c. Location -			-/42
altimore,	tment of tant: If it		1√2 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spacify) -	20b. Piace of comatai	Lawn	Mem.	Park	6-23-98	Hager			land
Ba	Depar Impor any In		21. Signature of Funeral Service Licen	Menn	A			ress of Facility .son Blvd.		FUNERAL stown, M			
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failura. List only of	pilications that caused tona causa on each line	the death. Do i	not entar th	ne mode of d	lying, such as cardia	c or reaplratory a	rrest,		Approxime Interval Be Onset and	tween
	/Medical		immediata Cause (Final disaasa or condition	a. Congest	tive H	eart	Fai1	ure			17	day	
п	Examiner		resulting in death)		Due to (or as a							uuj	
	D #	ilne		, and Met	astatio	can	cer to	bone pri	mary si	te unkno	wn	l ye	ar
	rificate be executed ng physician end es the burial-transit	Examiner	Sequentially list conditions,	С	Due to (or as a	consequan	ice of):						
68760,	be esician buna	alE	Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury	c									
687	licate phys s the	Medical	that initiated events rasulting in death) Last	D	oua to (or as a c	consequan	ce of):				1		
Box		M/u		d							1		
Ď	death d for	Icia	Part li. Other significant conditions co	ontributing to death but	t not reculting in	a the unde	rheina cousa	given in Part i	23h Did	tobacco use co	ntribute to	the cause	of death?
P. O.	that the death cer led by the ettendir deteched for use	Physician/I	Tarri. Other argimicant conditions of	ATTRIOUTING TO GENERAL DUI	t not resulting ii	i ina unua	nying cause	given in Fatti.		Yes 2 No			
	es tha	by P											
Division of Vital Records,	ew requires seen seen seen seen seen seen seen s	Completed								an autopsy ormed?	com	re autopsy ilable prior ipletion of eath?	to
<u> </u>		Con							1 🗆	Yes 20 No	1 🗆	Yas 2] No
/ita	delan: The certificate rector, pag	Be	25. Was case referred to medical axaminer?						ath (Check only	one)			
7	Physic this ca	70	1 ☐ Yes 2 ☒ No	Hospital:			3LI DOA			dence 6 Oth			
U C	tending P Jeath. tor: After t	lon:	27. Mannar of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. 1	Time of njury	28c. In		28d. Describe	how injury occur	ed		
S	Attending Physician: or death. sctor: After this certific by the funeral director,	cat	2 ☐ Accident investigation 3 ☐ Suicida 6 ☐ Could not be		n. Athema to			Yes 2 No	296 Location	Ctunes on a Alumb	as as Ound	Davita Abu	
2	To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: A completely filled in by the fi	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)				City or To	Street and Numb wn, State)			TIDer,
	Hosp 24 hot Funei tely fil	edical	29a. Cartifier (Check only one) 1 ☐ Certifying Phy	vsician: To the bast of eliner: On the basis of e	examination and	, daath oo d/or Invest	curred at the igation, in my	time, date and place opinion, daath occu	e, and due to the urred at the time,	causa(s) and ma date and place,	nner as sta and due to	ited. the causa((s)
	ithin ithe	Med	29b. Signature and the of certifier	and manner state	ed.			nse number	1	29d. Data signe			
	£ ≱ £ 8		121. 01.2	, A. W	15								
			30 Name and address of names into	completed sever of de	ath (Itam 00a)	Time De-	**	D01062		June 2	۷, ۱	770	
			30. Name and address of person who co					Washing	ton St.	Hage	rsto	wn.	MD
	Sta	tę	31. Data filed (Month, Ray Year) 2 1	OOQ 32. Regista								,	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death Month **Physician** Norma Elaine MILLER June 14 /Medical 4e. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Keedy Home Boons bo Boonsboro Washington 5. Social Sacurity Number Memorial 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) **Funeral** 1□M 2XF 217-12-2658 74 Director Jan. 28, 1924 Usuel Residance of Decedant the Marylend 10a. Stete 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with Spiceberry Court 21740 USA Funeral 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puarto Rican, etc.) 11. Maritel Stetus 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Giva Yeer or Dates: 1 Naver Merried 2 Married natural, or 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within end Mental Hygiena. College (1-4or 5+) Elementery/Secondery (0-12) homemaker her own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme)

Herman Lee Harbaugh 19e. Informent's Neme/Reletionship (Type, Print)

Bertha Mae Ausherman 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

Joseph R. Miller, III - son 20a. Method of Disposition

17335 W. Washington St., Hagerstown, Md. 21740 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete Date

Cedar Lawn Memorial Park 6-17-98 Hagerstown, Maryland

1 Burial 2 □ Cremetion 3 □ Ramoval from State 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Suneral Service Licenses

22. Name end Address of Fecility MINNICH FUNERAL HOME

23a. Pert1. Enter the disease, or complications that ceused the daath. Do not enter the mode of dylng, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

415 E.Wilson Blvd., Hagerstown, Md. 21740 Approximete Intervai Between Onsat and Death

Immediate Cause (Final disease or condition resulting in deeth)

Ruptury Abstonice Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events rasulting in deeth) Lest

Due to (or es e consequence of):

Due to (or es a consequence of):

Pert il. Other significant conditiona contributing to death but not resulting in the undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | 4 Hinknown

1998

4:07 AM

Birthplace (State or Foreign Country)

10d. Insida City Limits 1 ☐ Yes 2 No

Maryland

white

Anterio relevote Cardiangela since Distato mallity

Hypertenia Charic ortucta

24b. Were autopsy findings evelleble prior to completion of ceuse of deeth? 24a. Wes en eutopsy

Imony Dines Hypothyrainin

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 Yes 2 LNO

Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Nagestown, mo 21740

27. Menner of Deeth 1 Naturel 2 Accident 3 Suicide

4 Homicide

28e. Dete of Injury (Month, Dey Year) 5 Pending Investigation 6 Could not be determined 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and pleca, and due to the cause(s) and mannar steted.

29b. Signetura and title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

- Take mo

P1081 G

June 15, 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 334 mill 5t.

Vasant Datta MD 31. Dete filed (Month, Dey, Yeer) JUN 15 1998

32. Registrar Signeture

State Registrar

Vorma

permit. Peges 1 and 2. Depertment of Health et

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important: If it any injury or o

Physician /Medical

Examiner

physician and the burial-transit

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certificate

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After

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To the Within 2

6 24 hours

efter deeth Director:

law requires that the death certificate be axecuted

Records, P.O. Box 68760,

Division of Vital

Vorma

Examiner

Physician/Medicai

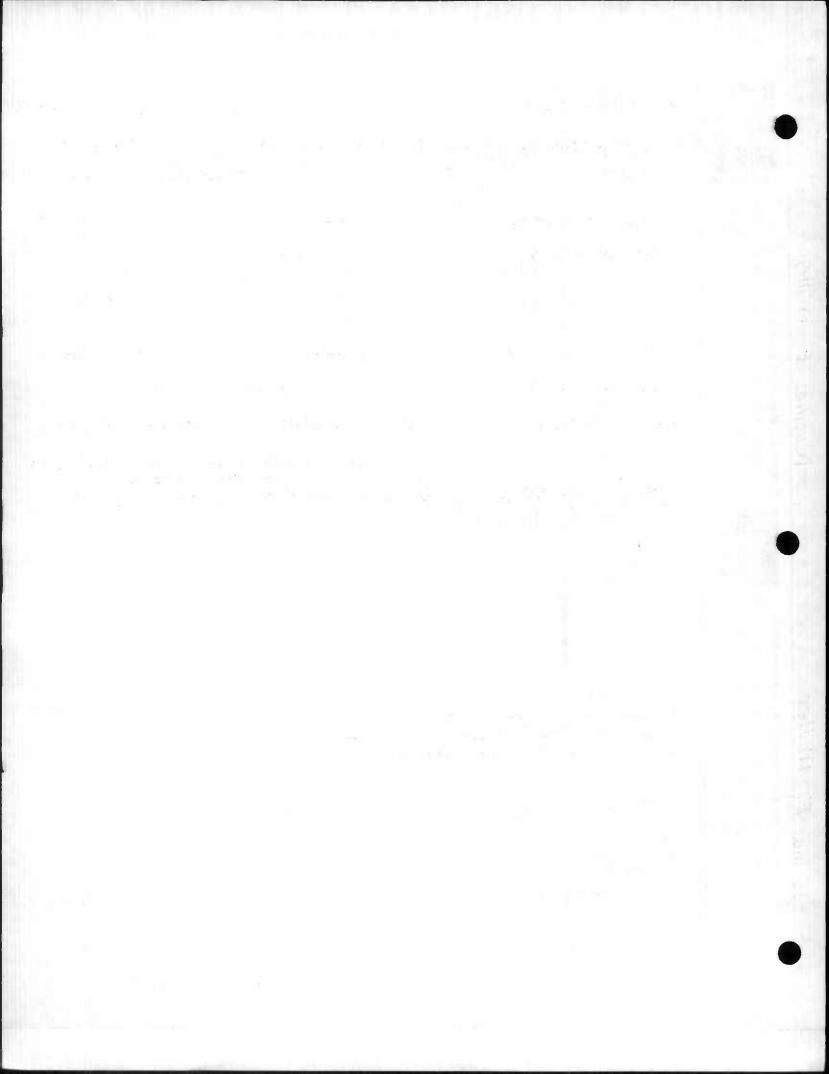
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Completed

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State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Deeth **Physician** Month Marie Philomena 1998 10:45 AM June /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fahrney-Keedy Memorial Washington 9. Birthplace (State or Foreign Boonsboro Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2⊠F 86 420-05-7237 Director 4, 1911 Usual Residence of Decedent deeth with the Meryland 10a State 10b. County 10c. City, Town or Location tam 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at Director Jefferson Leeds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 2nd Avenue 35094 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 21 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Heelith and Mentel Hygiene. Important: if item 27 is marked other than *any Injury or other traumatic event, in whom Eiementary/Secondary (0-12) Cotiege (1-4or 5+) 0 - 12Marie 0 homemaker her own home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Katz Norah Ahern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10725 Hartle Drive, Hagerstown, Maryland Mrs. Anne K. Macon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete 1X Burlai 2 ☐ Cremation 3 ☐ Removal from State June 20 4 ☐ Donation 5 ☐ Other (Specify) Elmwood Cemetery 1998 Birmingham, Alabama 22. Name end Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee

kane

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one ceuse on each line,

Physician /Medical Examiner

signed by t

hes certificate

I or Attending Physician: efter death. Director: After this certific

To the Hospital of within 24 hours a To the Funeral Completely filled in the Funeral Completely filled in the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second seco

Division of Vital

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Completed

Certification:

Immediete Ceuse (Final disease or condition resulting in death) attending physician for use es the burie Physician/Medical

Approximate Interval Between Onset and Deeth vaterly Due to (or as a consequence of) athero-selvos Due to (or as a consequence of) Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Piliellalie 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings evallable prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case reierred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ₽ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 26b. Time of 28d. Describe how injury occurred 28c. Injury a Work? 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

29b. Signature end title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

415 East Wilson Blvd., Hagerstown, Maryland 21740

Alabama

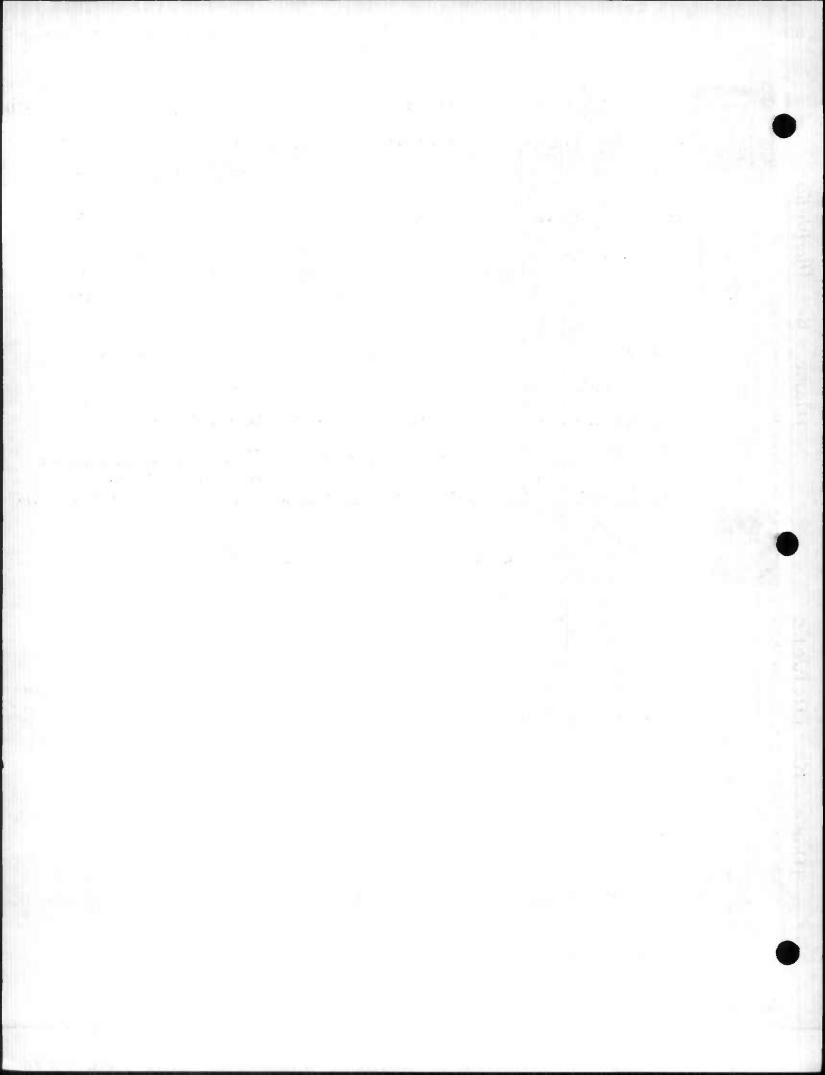
white

10d. Inside City Limits

to Yes 2 No

D32518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date tiled (Month, Day, Year) **JUN 15**



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month **Physician** Gladys Viola MAHONE June 6, 1998 1:00 a. m. /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Avalon Manor Hagerstown Washington ff Under 24 Hrs. Hours Min. Nov. 11, 1904 5. Social Security Number If Under 1 Yeer Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖺 F 220-09-7771 93 Yrs Director Maryland Usual Residence of Deceden death with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. fnslde City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must be notified at Maryland 1⊠ Yes 2□ No Washington Hagerstown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 Winter Street 21740 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours efter of the the the end Mentel Hygiena.

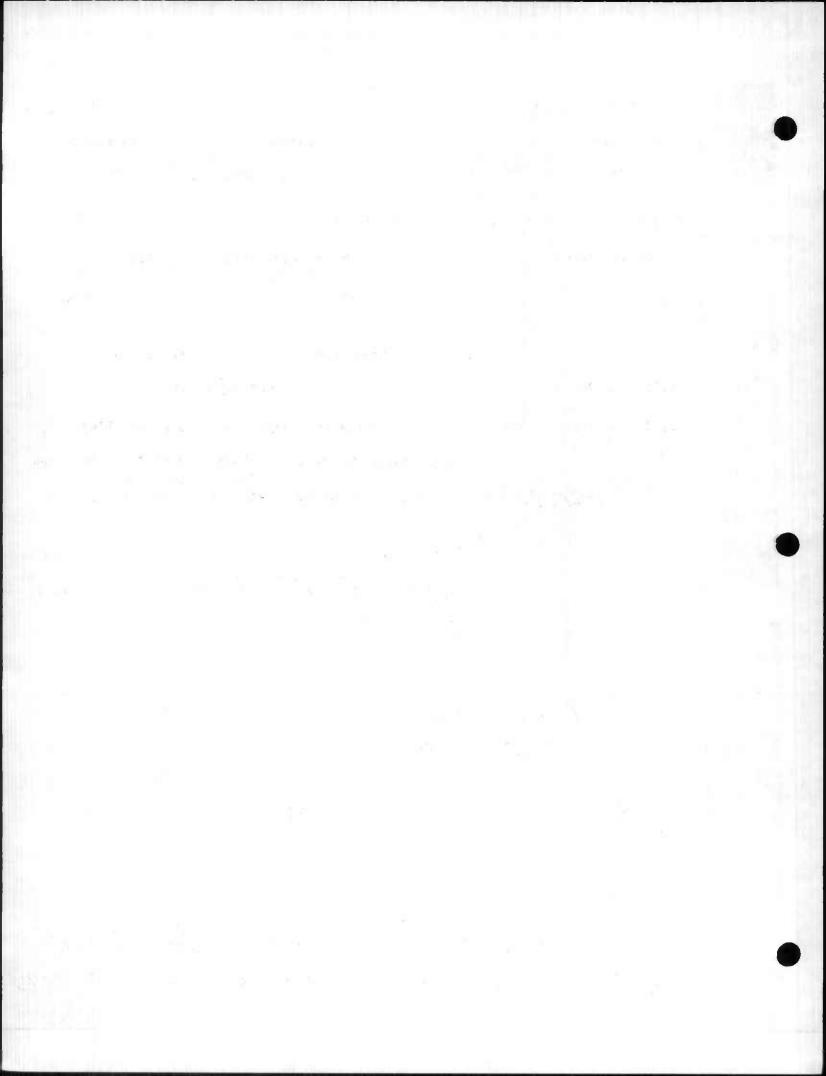
nt: If them 27 is marked other than "natural; or the 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: white Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) homemaker her own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) William H. Renner Cora May Baker 0 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Mahone - son other 623 George St., Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ₺ Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or Injury or Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 6-9-98 21. Signature of Euneral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 7415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner PACT INFECTION Examiner requires that the death certificate be axecuted physician end the burief-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Records, P.O. Box 68760. Physician/Medical Due to (or as a consi 80 950 for signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ATHROSCLEROSIS No No 3 Probably 4 Unknown 1 Tyes þ 24b. Were eutopsy findings aveilable prior to Completed 24e. Wes an autopsy peed completion of ceuse of deeth? page 2 s 1 ☐ Yes 2 ☐ No certificata Division of Vital or Attending Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: After Naturel 5 Pending after deeth. Director: Aft 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 29a. Certifier (Check only one) 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical within 2 To the 20d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JUN 1 2

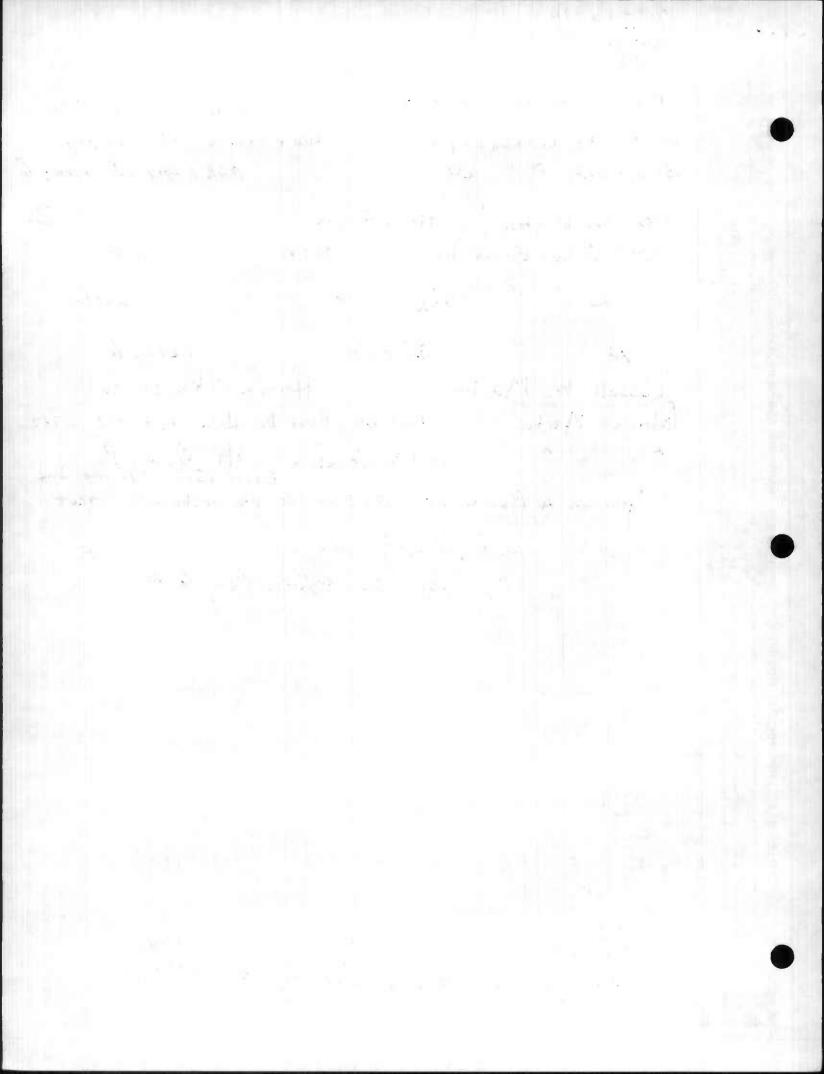
32. Registrar's Signeture

relia Davidson



6-9-98 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **¥**る Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** MARLIN EARL LERDY 5 June /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner County Hospital Washington
5. Social Security Number OLG Pr S-If Under 24 Hrs. Washing town ton If Under 1 Year 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, 9. Birthol 6. Sex Waynesbory ta **Funeral** Min. 12M 2 F Months Days Hours 188-09-5372 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene. 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 € No Director MD Washing Magerstowy 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examinating result be a 21742 215A 1048 Dr alley Drook Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No IYes, Give 1944 Year or Dales: 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. White þ 3 Widowed Divorced 11946 Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) TRuck Driver 12 Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Kauttman arliv ussell ermie uformant's Neme/Reletionship (Type, Pri 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10+8 Valley E. McNaney Brook Dr. Health a Md 21742 lagers town Itam 27 other t 20b. Placa of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If It 1 Burial 2 Cremation 3 Removal from State permit. Page Department and Zion Cemetery 6 Quincy 4 Donation 5 DOther (Specify) Ta 22. Name and Addrass of Facility Greve Home, Duc Funeral 21. Signature of Funeral Service Licenses S Broad ST 50 Waynesboro Bowerso 17268 ames Part1. In er the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheen failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SAJ Examiner Examiner physician and the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence ot) Division of Vital Records. P.O. Box 68760. Physiclan/Medical Due to (or as a consequence ot) 80 use signed by the e 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No by 24b. Wera autopsy tindings available prior to completion of causa of death? been sig Completed 24a. Was an autopsy performed? page 2 s has ils certificate h 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case reterred to medical examiner? Be 28. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Impatient Certification: To 1 Yes 20 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Naturel 5 Pending 1 ☐ Yes 2 No Investigation deeth. 2 Accident within 24 hours after deeth To the Funeral Director: / completaly filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, streat, factory, offica building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only one) within 2 To the F \$ 29d. Date signed (Month, Day, Year) 29b. Signature aggititle of certifie 29c. License number 0 tho completed ceuse of death (frem 23e) (Type, Pint) address of person JUN 08 32. Registrar's Signature State 1998 wha Davidson Registrar **DHMH 16 Rev 6/95**

Amend 19A

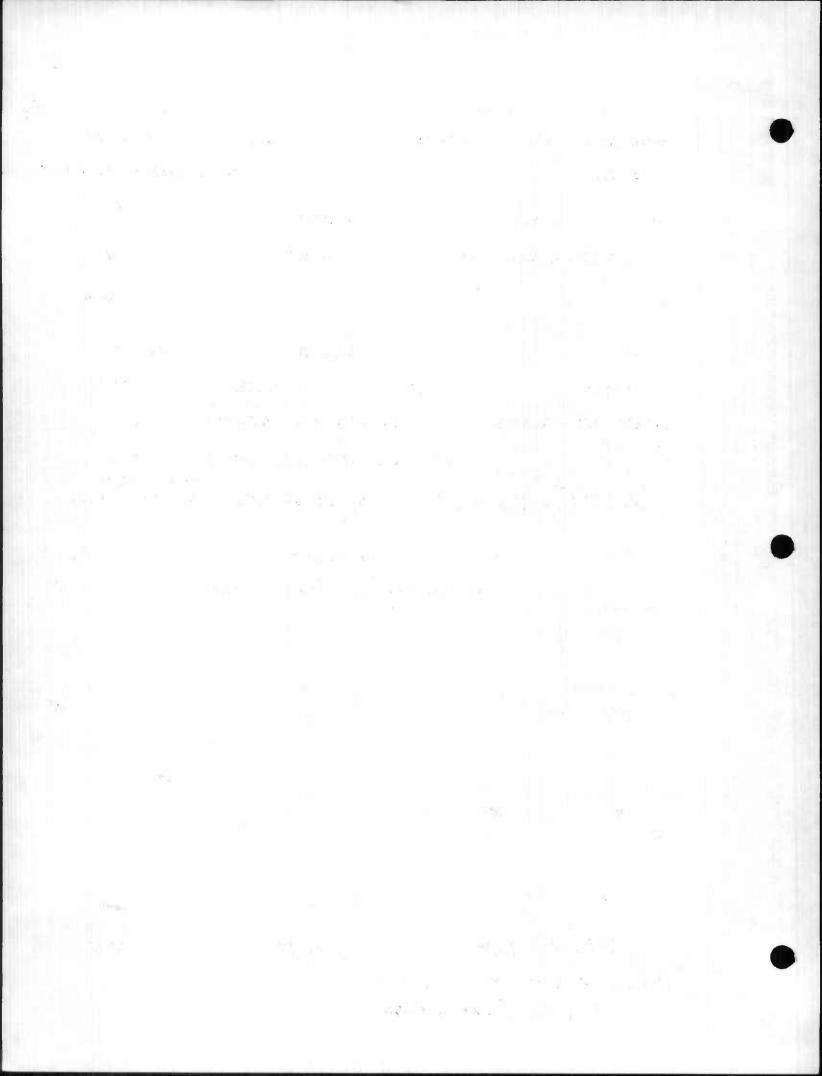


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 **Physician** MUMPER R. ANNA 6 IM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 24 Hrs. 8. Dete of Birth
Houra Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2X F Months Deys Yrs. APRIL 10.1910 PENNSYLVANIA 88 Director 208-03-9513 Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City. Town or Location 10d. Inside City Limita 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director SALISBURY WICOMICO 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21801 U.S.A. B 316 1514 RIVERSIDE DR. Funeral death 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Yeer or Detes: Was Decedent of Hispanic Ongin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or hand fijury or other traumate. Black, White, atc. 1 ☐ Nevar Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: Specify: WHITE by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ROCKEY ROCKEY BERTHA 2 CHARLES 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) SALISBURY, MD 21804 CAROLYN RASH - DAUGHTER 355 CAREY AVE. Baltimore, 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Buriel 2 □ Cremation 3 □ Removal from State 4 ☐ Donetlon → Other (Specify) 6-27-98 SALISBURY, MD WICOMICO MEMORIAL PARK 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility 705 E. MAIN ST. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. SALISBURY, MD 21804 Approximata Interval Between Onset and Deeth Physician Correlin Julimmary /Medical immediata Cause (Final disease or condition resulting in death) Examiner Examiner bring amatrice MTHS physician end the bunal-tran Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Ceuse (Diseese or Injury that initiated evants resulting in death) Last P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause givan in Part I. the 23b. Did tobacco use contributs to the cause of death? signed by I 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy tindings available prior to completion of cause of deeth? 24a. Wes an autopsy Completed peed hes 2 0 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Othar (Specify) 1 Yes 20 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 10 funeral 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Dascribe how Injury occurred Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be datermined 3 ☐ Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours a To the Funeral D complataly filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifian 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of daath (Itam 23a) (Type, Print) M. WGOD, JUN 26 1998 31. Date filed (Month, 39 Registrar's Signatura State Registrar

DHMH 16 Rsv 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year HODGES MORRIS 06 20 98 0655 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth PARSONSBURG

ar If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)

COLUMN Min. 15 15 15 15 US 50 AT PARSONSBURG ROAD WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday). 16 Yrs. If Under 1 Year 9. Birthplece (State or Foreign Country) 1981 SALISBURY, MD. 6. Sex 1 M 2 □ F Months Deys 213-98-2130 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits **SALISBURY** 1 Yes 2 No WICOMICO 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? BOOTH STREET USA 21801 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 [V] No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondery (0-12) College (1-4or 5+) OCEAN CITY FAST RESTUR LABORER 17 Fether's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) REGINA COOK DANIEL FONTAINE 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADDRESS SAME AS ABOVE REGINA C. FONTAINE 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 6-26 HEBRON. MD. SPRINGHILL MEMORY GARD. 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD; SALISBURY, MD. 21801 Drella Part1. En ler the disease, or complications That caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart feilure. List only one quius on each limit. Approximate Intervel Between Onset and Death Immediete Cause (Final MULTIPLE TRAUMA Due to (or as a consequence of): VEHICLE ACCIDENT Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Was en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) HIGHWAY Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation tnjury 1 ☐ Yes 2 X No PASSENGER-2 VEHICLE ACCIDENT 06-20-98 0545 6 Could not be determined 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify)

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ate hes been signe page 2 should be

certificate

After this

To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

The lew requires that the death certificate be executed

Box 68760.

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Funeral

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Baltimore, Maryland 21215-0020

d 2 should be II Ih and Mental H 7 is marked off

permit. Pages 1 and 2 should be Department of Health and Mental. Important: If Item 27 is mental. any injury or

the Medical Examiner Illed within 72 hours after Hygians. Ther than "natural", or the

Director

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was cese referred to medical 1 Yes 2 No

29b. Signature and title of certitier

27. Manner of Deeth

1 Naturel

2 Accident 3 Suicide

4 I Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

06-20-98

PARSONSBURG

MARYLAND

29a Certifie

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner as stated. Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

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D.M.E.

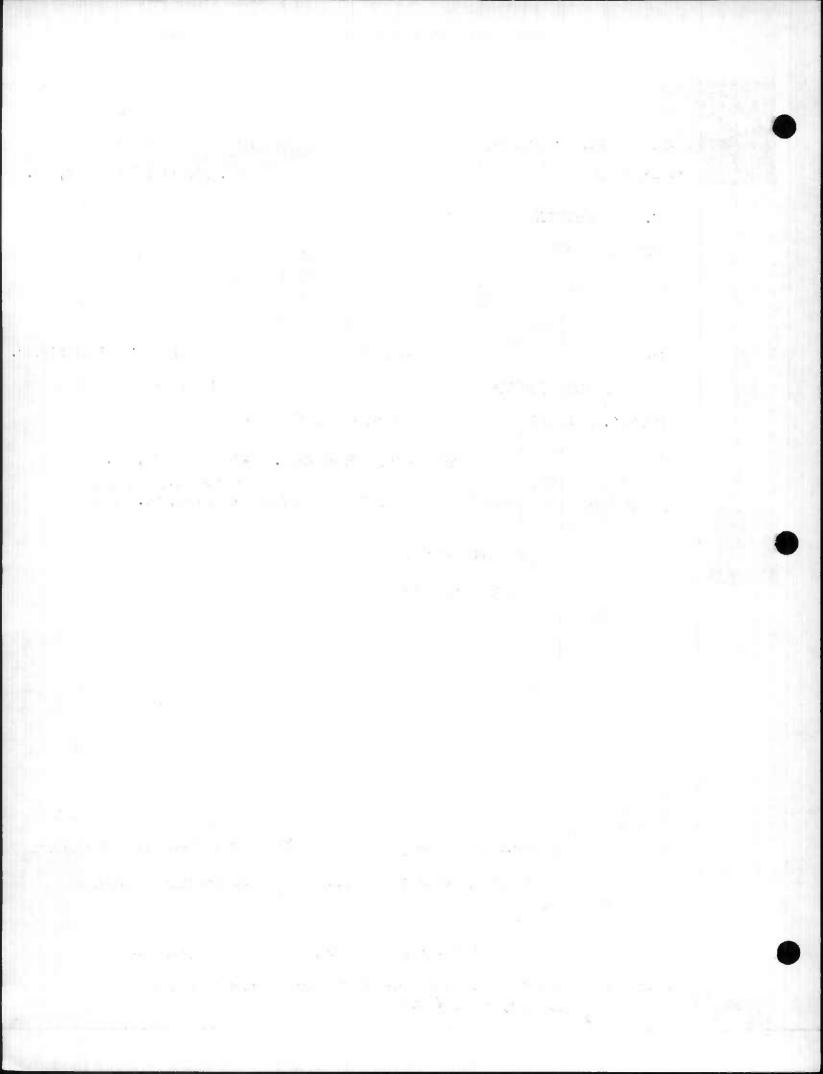
30. Name and accress of person who completed cause of death (Item 23e) (Type, Print)

CHRISTOPHER S. SNYDER, D.O., 108 PINE BLUFF ROAD, SALISBURY MD 21801 31. Date filed (Month, Day, Year) 22. Registrat's Signa@re

US 50 AT PARSONSBURG ROAD

JUN 26 1998

State Registrar

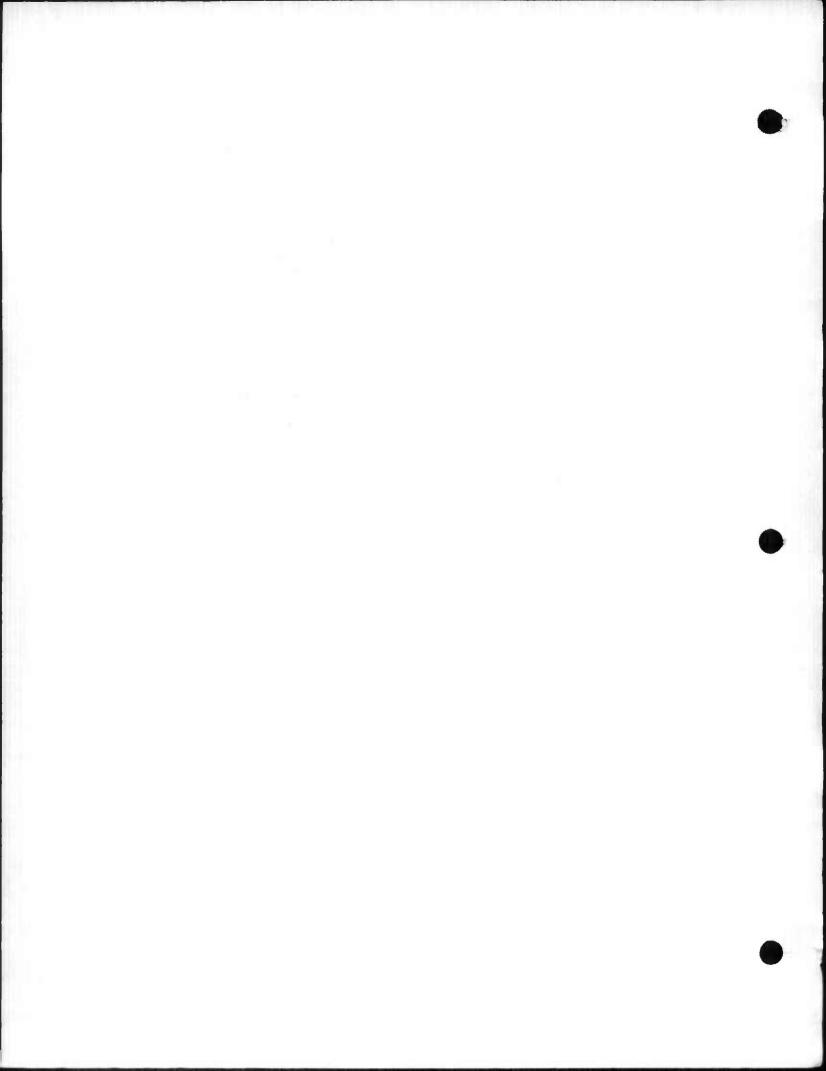


TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be written at the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of th BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

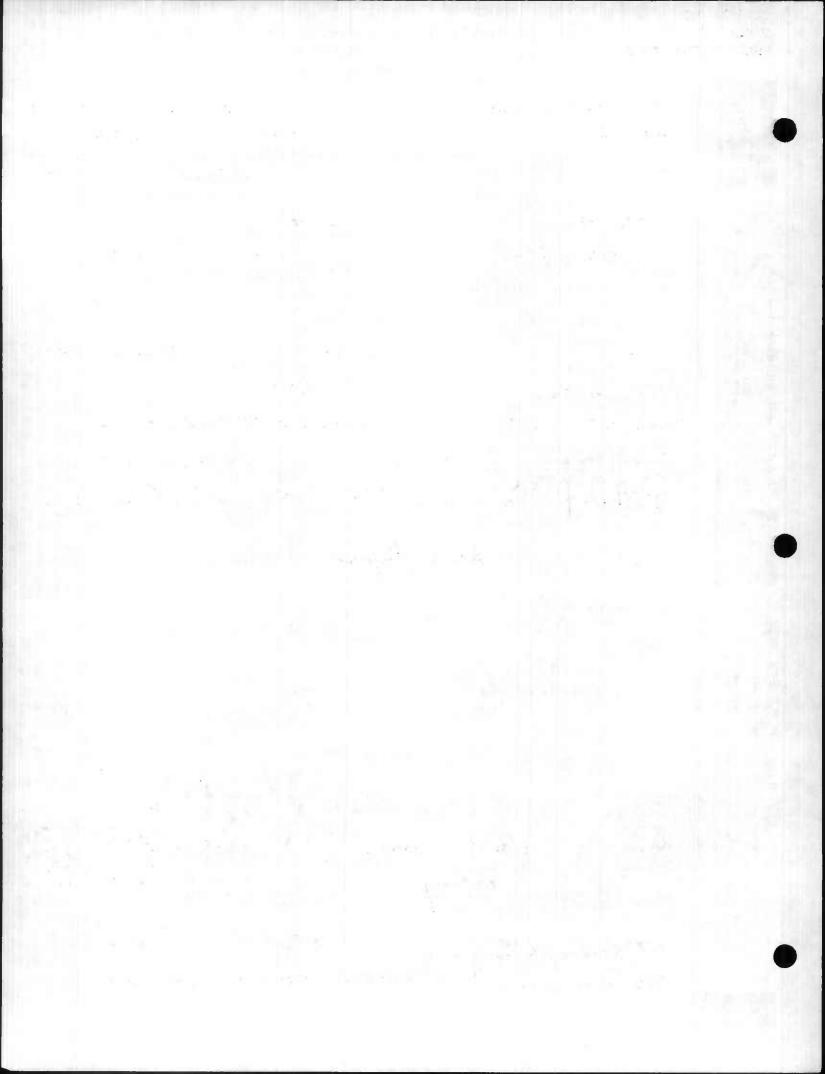
	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AND	MENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	Forrest Naaman	. Nulph			June 18	, 199	8 5:00 A.M.M
	4. SOCIAL SECURITY NUMBER 312-18-4202			IF UNDER 1 YEAR IF UNDER 24 HRS.	7 DATE OF BIRTH	0.00	RTNPLACE (State or Foreign untry)
	9e. FACILITY NAME (If not institution, give si	1 XM 2 D F	/ 8 YRS.		Feb. 25,19		rdiania
œ	11321 Coppermi		1	b. CITY, TOWN OR LOCATION OF E	DEATH	9c. COUNTY O	
18	RESIDENCE OF DECEDENT	ne ka.		Woodsboro		tre	derick
DIRECTOR	Md. F		10c. CITY,	TOWN OR LOCATION			10d. INSIDE CITY LIMITS?
	MCL. F	rederick		Woodsboro			1 TYES XX NO
RA	11321 Coppermi	no Rd		101. ZIP CODE 21798		277	F WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N U.S. ARMED	13. WAS DECENDENT OF HISPA	NIC ODIGIN2 (Specify Voc		I.S.A. ACE — American Indian.
	1 Never Married 2 Merried	FORCES? 1 YES	2 NO	If yes, specify Cuben, Mexic	an, Puerto Rican, etc.)	В	eleck, White, etc.
) BY	3 Widowed 4 Divorced		41-46	X		3	White
TED	15. DECEDENT'S EDUK (Specify only highest grade	Completed)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use	k done during most of working	16b. KIND OF BUS	INESS/INDUSTR	Y
PE	Elementary/Secondary (0-12)	College (1-4 or 5+)		stodian	Cal	P	
COMPLET	17. FATHER'S NAME (First, Middle, Last)	2	ca		Sch AME (First, Middle, Maiden S		
BEC	William Nulph				Siler	Julius in a second	
TO BE CON	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street and Number or Rural		, State, Zip Code)	
	Janet Gill (Da	ughter)	11321	Coppermine Rd.	Woodsboro.	Md. 217	198
180	20e. METHOD OF DISPOSITION 1 Buriel 2 X Cremation 3 Remo	oval from State Con	PLACE AND DATE OF	DISPOSITION (Name of colace)	DATE 20c. LOC	ATION — City of	Town, State
	4 Donetion 5 Other (Specify)	Sm	ithsburg	Crematory June	1 ₁ 9,1998 Sm	ithsbur	ig, Md.
a year	Dougin of	The state of	2	David Eurotal	Home 12525	Bradbu	vry Ave.
	7 SENIUS W.	Mure	_	Davis Funeral	nome Smith	sburg, N	ld. 21783
	23. PART I. Enter the diseases, or c shock, or heart failure. I	omplications that caused List only one cause on e	d the death. Do not sch line.	enter the mode of dying, su	ch as cardiac or respir	ratory arrest,	Approximate interval Between
	IMMEDIATE CAUSE (Finel disease or condition	MULACO	POIN	ISCHEM	NA		Onset and Death
, and a	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF:	10011011	11-7		hours
		HYPO>					days
0 1	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	1			11 4
CA	CAUSE (Disease or Injury	Metant	ratic	hung can	cer		Month
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):				
CEF							
AL	PART II. Other significent condition	s contributing to deeth b	out not resulting in	the underlying cause given in	Part I. 24a. WAS AN / PERFORI		24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
MEDICA					1 [] YES 21	DHO.	COMPLETION OF CAUSE OF DEATH?
							1 _ YES 2 _ NO
PHYSICIAN:	DID TOBACCO USE CONTR				N 🗆		
S C	EXAMINER?	HOSPITAL:		THER:			
HYS	27. MANNER OF DEATH	1 Inpetient 2 ER/Outp	28b. TIME	☐ Nursing Nome 5 Residence DF 28c. INJURY AT	6 ☐ Other (Specify) 26d. DEŞCRIBE NOW IN	LIURY OCCURED	
5 1	1 Netural 5 Pending	(Month, Day, Year)	INJUE		Too. DEGOTIDE NOW IN	SONT OCCORED	
D BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, term, stre	et, factory, office	281. LOCATION (Street or	nd Number or Rur	al Route Number,
	4 Homicide determined	building, etc. (c)oc			City or Town, State)		
COMPLETED	29a. CERTIFIER (Check only) CERTIFYING PNYSIC	CIAN: To the best of my know	ledge, death occurred	at the time, date end place, and du	e to the cause(a) and mans	ner ee stated.	
Š.	one) 2 MEDICAL EXAMINE	3: On the besis of examination	n and/or investigation,	In my opinion, death occured at the	e time, date and place, end	due to the caus	se(s) and manner as stated.
w l	296. SIGNATURE AND TITLE OF CERTIFIER	•		29c. LICENSE NU	MBER	29d. DATE SIGN	IED (Month, Day, Year)
TO B		WW. D.		1040	+164	P 6/2	-6/98
	30. NAME AND ADDRESS OF PERSON WING	SE Ave. [ATN (ITEM 27) (Type, P)	EDERICK	MD 217	Ol A.Z.	Henazi
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE				cg.a.o.c
	20F AT 16	39B Lulian	Savidana B.				



land /	Department	of Health and	Mental Hygien

i.	ILAOIN M	.Cn	AEL NETZ	St	ate of	Marylar		artment ertificate			and N	lental Hy	giene Reg. No.	6 2	1432	
			Decedent's Nama (First, Middle, Last)									2. Date of Death Month Day Year			3. Tima of Death	
	Physici * /Medic		SHAUN MICHAEL NETZ									JUNE 20, 1998			2330 PM	
	Examir	_	As Carifford Food Institution also street and numbers											N		
	Funeral Director		5. Social Security Number	6. Sax	x) If Under 1 Months	Year	If Under	24 Hrs. Min.	8. Data of Bird (Month, Da	th V Vaerl	9. Birth	place (Stata or Foreign htry)	
п			212-04-8806	1.83 M				World bays		Hours Will.		JULY 2,	1981	M	MARYLAND	
	p .	ector	Usual Residence of Decedent 10a. State 10b. Count			ity, Town or L	ocation							10d. Inside City Limits		
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	the N		PENNSYLV. FRA 10e. Sfreef and Number	NKLIN			_	10f. Zip Code					10c Citizen	of What Cou	nta/2	
Baltimore, Maryland 21215-0020	With Me or	ā	15458 SKYLINE DRIVE								.726	3		U.S.A		
	Seath res 23	era	11. Marital Status	12. W	12. Was Decedenf Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No			Was Deceder	Vas Decedent of Hispanic Origin? (Spec			ecify Yes or No		14. Race - Amarican Indian,		
	iges 1 and 2 should be filed within 72 hours effer death with the Maryland at of Heelih and Mental Hyglene. If if tern 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, the Medical Example must be notified at	by Funeral Director	1 Never Married 2 Ma 3 Widowad 4 Divorce	rried 1				If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:				Rican, etc.)		Black, White, etc. Specify: WHITE		
		Pa	15. Decedent's Education 16a. Decedent's Usuel Occupation								16b. Klnd	of Business/In				
		To Be Completed	(Specify only high Elementery/Secondary (0-12)	ast grada com	a completed) (Give kin				ind of work done during most of workir O NOT use retired)			ing				
			11		College (1-401 54)				STUDENT			PUBLIC F		IC HIG	HIGH SCHOOL	
			17. Father's Name (First, Middle, Last) 18. Mother's Na								r's Nam	ma (First, Middle, Maidan Sumame)				
	should be ind Mental I marked or		MICHAEL E. NETZ LISA G. EC									ECTON	CTON			
	permit. Pages 1 and 2 sho Department of Heelth and I Important: If item 27 Ie ma any Injury or other traums PMSS.		19a. Informant's Name/Relation									al Route Numb			Code)	
			MICHAEL E. NET	Z/FATH	ER	001		8 SKYL		DRIV	E, S	TATE LI				
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8			Immediate Cause (Final			11	0 1) -	_						Oriser and Dadin	
	Examiner		disease or condition resulting in death) a. Head Impufes												0	
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	death certificate be executed e attending physician and of for use as the bunal-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	1		000 10 (01 85 6 001100	quorios oi).								
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σ.	To the Hospital or Attending Physician: The lew requires that the de within 24 hours after deeth. To the Funeral Director: After this certificate has been signed by the completaly illied in by the funeral director, page 2 should be detected.		Î □ Yes									Yes 20	2 No 3 Probably Unknown			
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	Hospital 24 hours Funeral staly filled		29a. Certifier 1□ Certify	ng Physician	: To the	best of my kn	ov dge, dea	th occurred at	the ti	me, date an	d place,	and due to the	cause(s) an	d manner as	Sates Many Land	
	To the Hospital or Attending I within 24 hours after deeth. To the Funeral Director: After completaly filled in by the fune.	edicai	(Check only one) ** CMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of th													
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			30. Name and address of person	who complet	ed cause	e of feath (Ite								0100-		
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Registrar



State of Maryland / Department of Health and Mental Hygiene | Q Certificate of Death 1. Decadant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month William Earl Neikirk June 16, 1998 1:12 P.M. /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Colton Villa Nursing Home Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | Month, Day, Year) 17 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Funerai 1 M 2 □ F 81 Marigland 187-16-5720 Vrs Director Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits traumatic avent, the Medical Examiner must be notified at Md. Director Washington Smithsburg 1 ☐ Yas 2 No 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 0 21783 U.S.A. 22327 Old Georgetown Rd. Herns 23a Funeral 12. Was Decedent Evar in U,S. Armed Forcas?

1 □ Yas 2 □ No ff Yas, Giva Yaar or Datas: 33-36 Was Dacadant of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarlcan Indian, Black, Whita, atc. Peges 1 and 2 should be filed within 72 hours efter or ment of Health and Mental Hygiene.
nnt: If Item 27 is marked other than 'natural', or fles inty or other traumatic avont, the Medical Earn's inty or other traumatic avont, the Medical Earn's inty or other traumatic avont, the Medical Earn's inty or other traumatic avont, the Medical Earn's inty or other traumatic avont, the Medical Earn's inty in the Medical Earn's inty in the Medical Earn's interpretation of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🛣 No þ 3 ☐ Widowad 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highast grade complated) 18e. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Welder Equipment Co. 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Surname) Grover C. Neikirk Ida Hollinger 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) Mabel C. Neikirk (Wife) 22327 Old Georgetown Rd. Smithsburg, Md. 21783 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2 Cremation 3 Regueval from State permit. Pege Department of Important: If any Injury or 5 Other (Specify Brown's Mill Cemetery June 19,1998 Greencastle Pa. 21. Signature of Funeral Service Lic 22. Nama and Addrass of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 Part 1. Entar tha disaase, or complications that causad tha daath. Do not antar the mode of dying, such as cerdiec or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Deeth **Physician** /Medical Immadiate Causa (Final mylloproliferative disader. Heav disease or condition resulting in daath) Examiner Examiner DENGNTIA 24ear ettending physician and for use es the bunel-transit The law requires that the death certificete be executed Sequentielly list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseasa or Injury that initiated avants resulting in daath) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of) ate hes been signed by the ette page 2 should be detached for Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Morle Records, Be Completed by 24b. Wara autopsy findings avellebla prior to completion of causa of death? 24a. Was an autopsy performed? certificate hes 1 Yas 1 ☐ Yas 2 ☐ No of Vital ual or Attending Physician: The star death.

al Director: After this certificate 25. Was case rafarred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: Nursing Homa 5 Residenca 6 Othar (Specify) 1 Yas 2 No Certification: To illed in by the funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Tima of Division 10/12 Natural 2 Accidant 5 Panding invastigation NIA 1 Yas 2 No NIA 10/12 M 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At home, ferm, streat, factory, offica building, atc. (Spacify) 28f. Location (Street and Number or Rural Route Numbar, City or Town, Stata) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in NIA Cartifying Phyeiclan: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature end titla of cartifian 29c. Licansa numbar 29d. Date signad (Month, Day, Year) D28365 6.16-98 30. Nema and address of person who complated cause of death (Itam 23e) (Type, Print) STRBET HAGERSTOWN 690 21740 JSHAM. 368 MILL MANZAR 31. Data filed (Month, Day, Yaar) JUN 18 1998 32. Ragistrar's Signatura State

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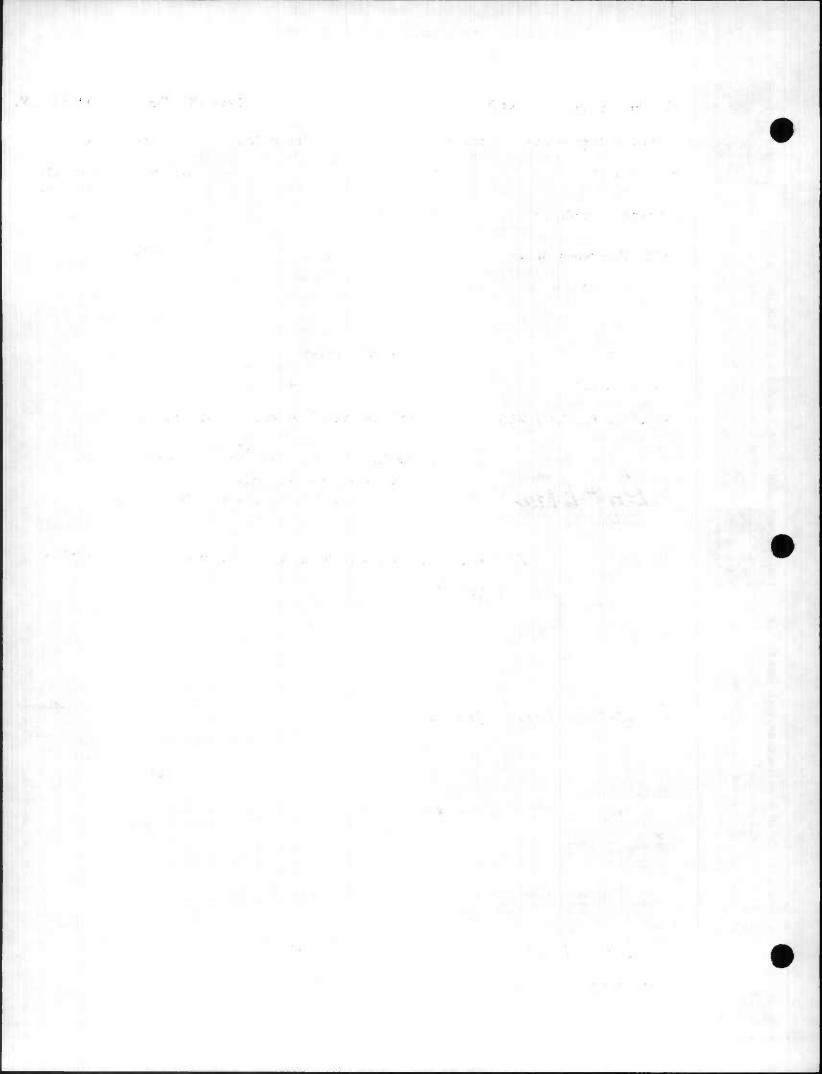
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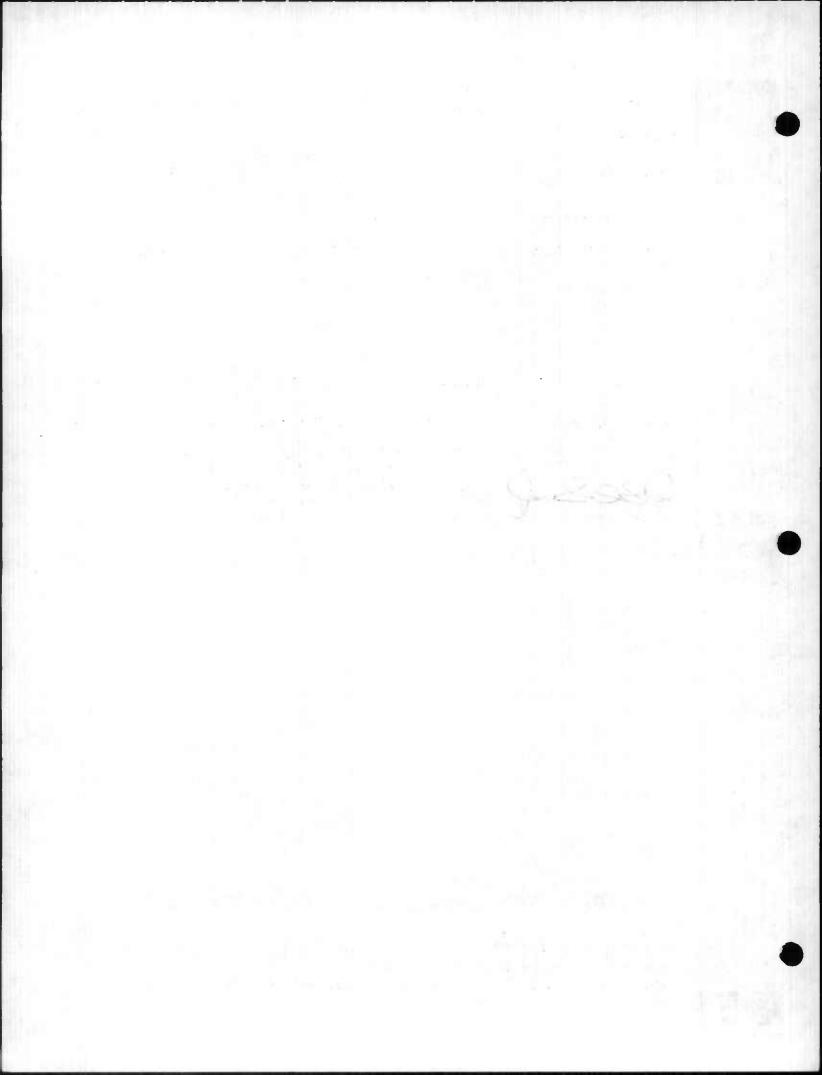
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N N	Afte er de ecto by tf	3 Sulcida 6 Co	uld not b tarmined	28a, Plac	a of Injury	- At homa, fai	rm, street,	factory, office		28f. Location	(Street and Numb	er or Rui	ral Routa Number,	
ā	tal or Attending P is after death. If Director: After the funerated in by the funerated in Certification:				and are to	-p								
									ima, data and plac opinion, daath occ					
	thin 24 hours thin 24 hours the Funer impletely fil	one)	1		nnar steted		a or mirable							
	To To To	29b. Signatura and title of ce	T. Contin						sa number		29d. Data signe	-	1	
		· (/V	1					1	37178		6-1	0	18	
		30. Name and address of per	son who	completed cau	usa of daet	h (Item 23e) (Type, Prin	nt)						
		J. Christoph	F	eminy /	MN		14500	ik M	0					
	State	31. Data filed (Month, Day, Y	ear)	1998 32.	Ragistar's	Signatura	n- Ran	dell						
	Dogiotion	43.113	0 6 8	1 . 2 . A . A	-TIENLE	IL THE WAY THE YOU	ex 11 1							



State of Maryland / Department of Health and Mental Hygiene 98

		1. Decedent's Name (First, Middle, L.	ast)				:	2. Date of Deat			ne of Death		
Physici /Medi	_	Julia	Mati	ilda		Poole		June 2	7, Day 1998	fear 9:	15 a.m.		
Examir		4a. Facility Name (If not institution, git 2007 Day Road	ive street and number,				Town, or Local		4c. County of Washi				
Funeral Director			Sex 7. A	ge (In yrs. lest birt. 87	hday) If Under Months	1 Year If Union Days Hou	der 24 Hrs. g	Date of Birth (Month, Day, July 3,	1910	9. Birthplace (Sti Country) Marylai	ate or Foreign		
/land		10a. State 10b. County		10c. City, Town	or Location					10d. Insid	le City Limits		
a-f sh	ctor	MD Washing	ton	Clear	Spring					1 🗆	Yes ANNo		
23a or 28	Funeral Director	10e. Street and Number 11416 Hanging R	Rock Road		10f. Zip	Code 1722		10	Og. Citizen of Wh				
if Health and Mental Hygiene. If Health and Mental Hygiene. If health and Mental Hygiene. Other traumatic event, the Medical Evaniner mant be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Noviced	12. Was Decedent Armed Forces 1 Yes 2 Y			lent of Hispanic cify Cuban, Mexi No Spec		fy Yes or No- can, etc.)		American Indie White, etc.			
natur	Completed	15. Decedent's E (Specify only highest gr	ducetion rade completed)	16a.	Decedent's Usua (Give kind of wor life. DO NOT us	I Occupation	nost of working	,	16b. Kind of Busi	ness/industry			
than	idmo	Elementery/Secondary (0-12)	College (1-4or	5+}	<i>iii</i> e. <i>DO NOT</i> us Iomemake				Own hos	me			
and Mental Hygiene. is marked other than aumatic event, the M		17. Father's Name (First, Middle, Las	t)		· Omemare		other's Name (First, Middle, N	faiden Sumame)				
ked o	To Be	George Day	id Cl	lopper			lia	Matil		Suffeco	01		
and N		19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address	(Street and Nu	n <i>ber</i> o <i>r Rur</i> al	Route Number,	City or Town, Si	tate, Zip Code)			
Health of Health other tra	10	Theodore C. Pool	.e	114	416 Hang	ing Roc	k Rd.,	Clear	Spring,	MD 21	722		
		20a. Method of Disposition XXX Buriel 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Contro	□Removal from State	Blairs	Valley	ther place) Church	of		Cloor S	nrina 1			
Depertment Important: If any injury or once.		21. Signators of Funeral Service Lice											
		23a. Per Exper the disease, or con shock, or heert feilure. List only	nplication that ceuse one ceuse on each l	d the death. Do no	ot enter the mode	e of dying, such	as cardiac or	respiratory arre	est,	Approx Interval	lmate Between		
nysician Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a ATHE	20 SCLE	CARDI	OVASCO	ILK DI	SEASIE	S S	ravs.			
	5			Due to (or as a co									
g physician end es the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	b. CON C	Due to (or as a co	onsequence of):	ART	3 AILU	RE		8	year		
ysicie	Cai	Cause (Disease or Injury thet initiated events resulting in death) Lest	C	Due to (or as a co	onsequence of):					×			
attending ph I for use es ti	Physician/Medical	resulting in death) Lest	d		X					×			
he att	Sici	Part II. Other significant conditions	contributing to death b	ut not resulting In	the underlying ce	euse given in Pa	ırt I.	23b. Did to	bacco use contr	ibute to the cau	se of death?		
igned by the s be detached	by Phy		none					1 □ Ye	98 2□ No 3	Probably	Unknown		
ate has been signed by the attendir page 2 should be detached for use	Completed							24e. Wes ar perform		24b. Were eutop available pr completion of death?	rior to		
	Cou							1 □ Ye	s 2XXVIO	1 🗆 Yes	2□ No		
ls certificate director, pag	Be	25. Was cese referred to medicel examiner?	Hospital				ace of Death (Check only one		D 1			
h. After thi funeral	tion: To	1 Yes 24 No 27. Manner of Death 1 Notural 5 Pending 2 Accident Investigation	Hospital: 1 Inpatie	ry 28b. Ti	me of jury	Do Internat	N/A 28	5 Reside	w Injury occurred	Daughter I	r's hom		
within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, fari c. (Specify)		, office	28	f. Location (Str City or Town	eet and Number , State)	or Rural Route I	Vum <i>ber</i> ,		
within 24 hours effer To the Funeral Dire completely filled in L	edical	29a. Certifier (Check only one) CXCartifying Pt 2 Medical Example (Check only one)	nyaician: To the best miner: On the basis of and manner sta	of my knowledge, examination and ated.	deeth occurred a for Investigation,	at the time, date in my opinion, c	and place, en leath occurred	d due to the ce at the time, de	use(s) and mannite and plece, en	ner as stated. d due to the ceu	se(s)		
To t	Dark I	29b. Signature and title of certifier	1.1		29c.	License numbe	er .	29	d. Date signed (nr)		
		Mangen g.	nay.		D	2836	5		6.29.	98.			
		30. Neme end address of person who											
		Manzar Shafi, N 31. Dete filed (Month, Day, Year) JUN 29 19	1.D., 368	Mill Strans Signeture a Davidson	eet, Hag	gerstown	, MD	21740					
Sta													

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ivid	-	Certificate of			ig. No.	21436	
Ī	Physic		1. Decedant's Nema (First, Middla, L Bernard	whitman	PALMER			2. Data of Deet Month June 27	Day	Yaar 3. Time of Death 5 3 1 Pm	
	/Medi Examir		4a. Facility Nema (If not Institution, gi				4b. City, Town, or L Hagers	ocalion of Death	4c. County	of Deeth nington	
	Funeral Director		5. Social Security Number 6. 219-05-2948		(In yrs. last birt	hday) If Under 1 Year Months Days	if Under 24 Hrs.			9. Birthplace (State or Foreign Country) Maryland	
	Maryland -f show	lor	Usuel Residence of Decedent 10e. Slele 10b. County Maryland Washing	ton	10c. City, Town					10d. Insida City Limits PCXYas 2 ☐ No	
	th with the 23s or 28s	Funeral Director	10e. Street and Number 247 East Howard	Street		10f. Zip Coda	21740	10	0g. Citizen of W		
020	be filed within 72 hours after death with the Manyland tal Hyglene. d other than "naturs!, or items 23a or 28a-f show event, the Medical Expriner nurst be notified at	by	11. Maritai Stetus 1 Nevar Married 2 Married 3 AWidowed 4 Divorced	12. Wes Decedani E Armed Forces? 1 X Yas 2 N if Yas, Giva V Year or Dates:	0	13. Was Decedant of lif Yas, epecify Cub		pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-		- American indian, k, White, alc. - white	
21215-0020	within ne.	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ada complated) Collega (1-4or 5-		Decedant's Uauai Occu (Giva kind of work dona lifa. DO NOT use ratire finisher	during most of word d)		16b. Kind of Bu furni	ainass/industry	
	2 should be filed very and Mental Hygie is marked other traumatic event, it	BeC	17. Fathar'a Nama (First, Middle, Las	")			18. Mothar'a Nam	na (First, Middla, A	/aidan Sumam	9)	
Maryland	should be and Mental I marked of	To		Luther Pa	-			Ethel M			
Mar	s 1 and 2 should f Health and Mer tem 27 is marks other traumatic		Mrs. Betty J. Al			Meiling Address (Stree			-		
altimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 i any Injury or other tr. once.		20a. Mathod of Disposition 1 Burial 2 Cramation 3 [4 Donation 5 Other (Special Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the	Removal from State	20b. Piace of cemeter	Disposition (Nema of y, cremetory or other ple lawn Memori	ice)	July 1,	20c. Location -	and 21742 City or Town, Stala Asport, Maryland	
Balt	permit. Departr Imports any Inje		21. Signature of Funarai Service Lice			22. Name and Address		innich F vd., Hag		Home , Maryland 2174	
			23a. Part1. Entar tha disaasa, or cor shock, or haart failure. List only	plications that caused ona causa on each lin	tha daath. Do n a.	ot antar tha moda of dyi	ng, such as cardiac	or raspiratory erre	est,	Approximata Interval Between Onset and Death	
	Physician /Medical Examiner		Immediata Causa (Final diseasa or condition resulting in deeth)	· Acot s	ugocas	ensequence of a carle	chin, a	urjuks		Sullen	
	D #	lner		, orter	lastics	e carlement	In Leavin			Year	
90,	tificate be executed ig physician and as the buriat-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	= 11							
Box 68760,	nibin use	nn/Medical	rasulting in death) Last Dua to (or as a consequence of):								
P.0	es that the death igned by the atte be detached for	y Physician/M	Part II. Other significant conditions	contributing to death bu	t not rasulting in	the underlying causa gi	van in Part f.	23b. Did to		stribute to the cause of death? 3 Probably 4 Unknown	
of Vital Records,	aw requir is been s 2 should	Completed by						24a. Was a perform	n autopsy ned?	24b. Were autopsy findings available prior to completion of cause of death?	
al R	The ata h page							1 🗆 Ya	as 28 No	1 Yes 2 No	
₹ K	Physician: The this certificate and director, pai	o Be	25. Was case rafarred to medical axaminar?	Hospital:		Ot Do. Ot	har	ith (Check only on			
		-	27. Mannar of Death	28a. Data of Injur (Month, Day	y 28b. T	ima of 28c. inju		oma 5 Amesida 28d. Dascribe ho		ar (Specify) ed	
Division	after death. Director: After d in by the funer	Certification:	1 Maturai 5 Pending 2 Accidant 3 Sulcida 8 Could not 1 4 Homicida	n oo Dissertial	ry - Al home, fai]Yas 2□No	28f. Location (St City or Town		er or Rural Route Number,	
	Hospita 24 hours Funeral tely fille	edical C	29a. Cartifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of and mennar slet	axaminetion and	daath occurred at tha ti for investigation, in my	ma, date and pieca opinion, daath occu	, and due to tha ca rred et the tima, da	ausa(s) and ma ate and piece, a	nnar as stated. and dua to tha cause(s)	
	To the within To the comple	Me	29b. Signeture end little of certifiar			se number	2		(Month, Day, Year)		
			30. Neme and address of person who			Type, Print)					
	Sta	te	Stary M. Co dev. a). 31. Data filed (Month, Day, Year)	18706 (AE) 32. Registra	37000 r's Signetura	DA. HAGEN	TOWN, MI)	21742	=		
	Registr		SARRY M. CONTENDS 31. Data filed (Month, Day, Year)	1998 De	ha Davids	n-Randoll					

DHMH 16 Rev 6/95

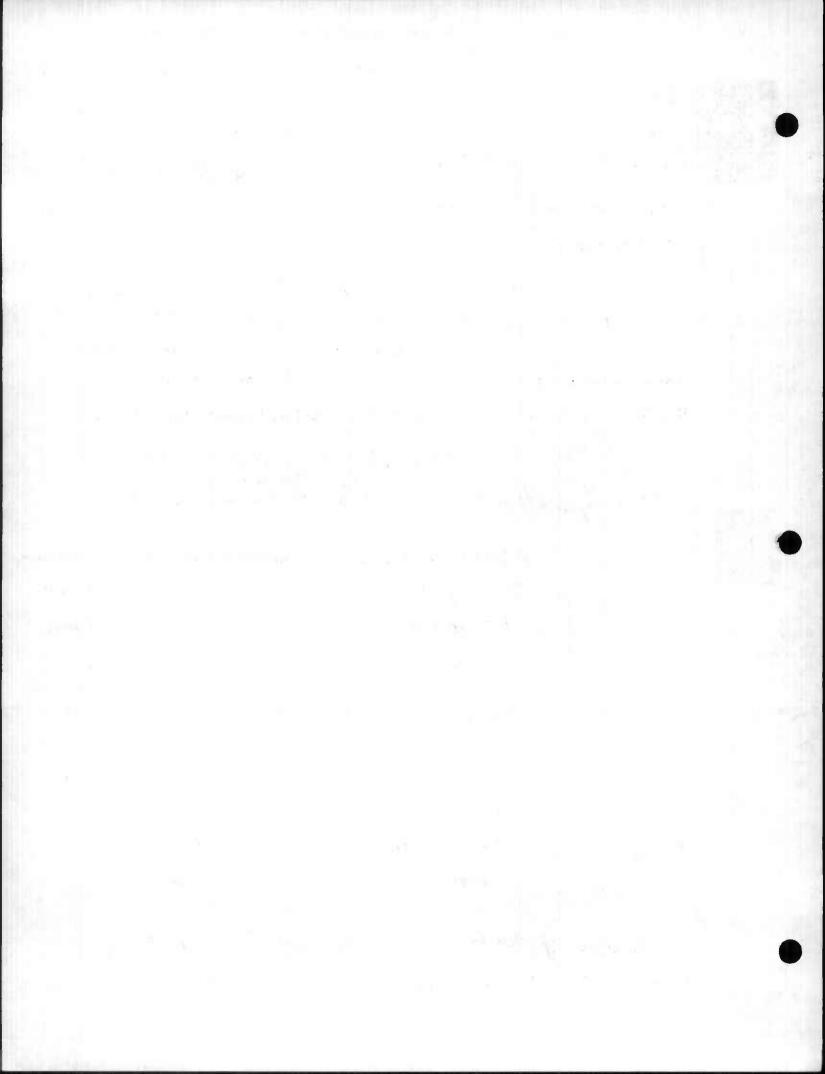
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mae Belle Payne Month **Physician** 11:30 7, 14 98 4c. County of Death June /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | if Under 24 Hrs. 5. Sociei Security Numbe 254-24-0027 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Dete of Birth (Month, Dey, Year) 1□ M 20XF Months Days Hours Yrs. Director May 18,1899 Jackson Co., GA Usuel Residence of Decedent the Maryland show 10a. State 10b. County 10c. City, Town or Location Hagerstown 10d. Inside City Limits items 23s or 28s-f shor Maryland Washington Director 1 ☐ Yes XX No 10f. Zip Code 21740 10e. Street and Number 750 Dual Highway 10g. Citizen of What Country? death v Funeral 12. Wes Decedent Ever in U.S. Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Meritei Stetus "natural", or item permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examines. 1 Yes 2 No
If Yes, Give
Year or Dates: t Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: py Specify: White 3 ₩ Widowed 4 Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Seamstress Clothing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Frances Elizabeth Davis James Stephen Latimer 19a, Informent's Name/Reletionship (Type, Print) William H. Payne –Son 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8005 Dogwood Drive, Fayetteville, PA 17222 20b. Place of Disposition (Neme of cametery, cremetory or other place)

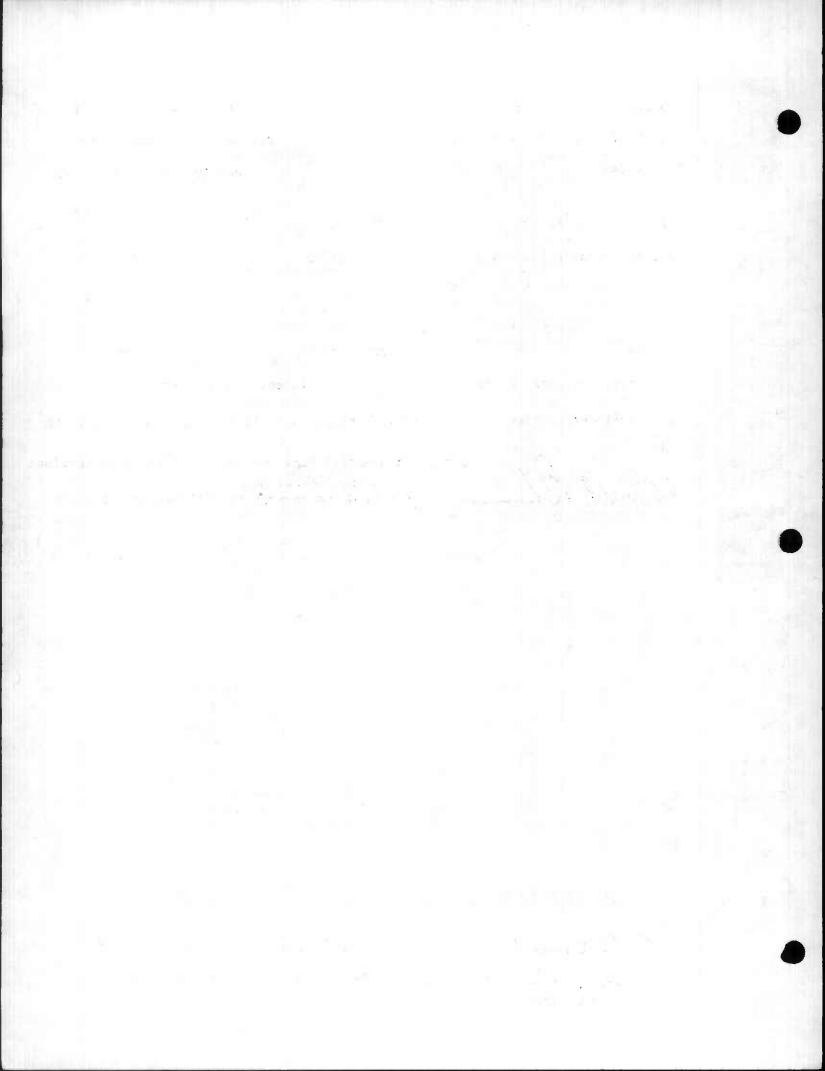
Resthaven Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Buriai 2 □ Cremetion 3 □ Removal from State 6/10/98 Frederick, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Solvious 22. Name end Address of Facility
Melvin T. Strider Co., Inc. P.O. Box 388, Charles Town, WV 25414 Miteles 23a Part 1. Enter the disease, or shock, or heart failure. List r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, tonly one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final A7HEROSCUEROTIC CARDIOVASCULAR DISBASE
Due to (or as a consequence of): disease or condition resulting in death) UNKNOWN Examiner WOSEPSIS.

Due to (or es e consequence of): 4DAYS Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 years DENGETIA Physician/Medical 8 Due to (or as a consequence of): Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown none Records, þ 24b. Were autopsy findings evallable prior to Completed 24a. Was en autopsy completion of cause of death? The law Dage 2 1 Yes 2 No 1 ☐ Yes 210 No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To ō this 27. Manner of Death Date of Injury (Month, Dey Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After Division Attending 1 Natural 5 Pending Investigation Injury 1 Yes 2 No death. NA 2 Accident NIA after death Director: 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street end Number or Rurel Route Number, City or Town, Stete) in by 4 ☐ Homicide 8 To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and menner as stated.
2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23e) (Type, Print) 368 STREET HAGERSTOWN MD 21740 MILL funa auton-fandale State Registrar



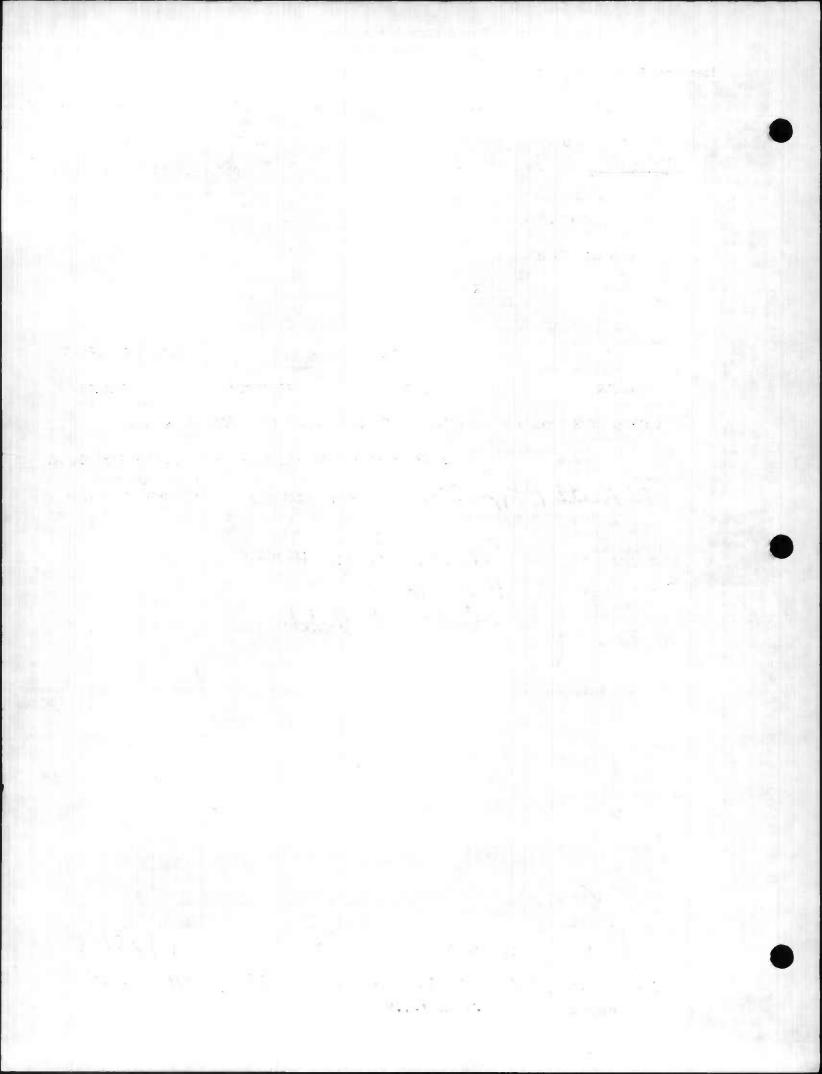
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	- 31	4 Para landa Nama (Carlotte III)			Certificate of	Death		Reg. No.	0 4	1300	
Physici /Medic		Decedent's Name (First, Middle, Last) Thomas Nelson Pott	s				2. Data of De Month June	Day 3	Year 1998	3. Time of Death	
Examin	ier	4a. Facility Name (If not institution, give street an				4b. City, Town, or L					
		202 East Franklin St			H Hadar 1 Van	Hagers	_		ashing		
_o Funeral Director		5. Social Security Number 219-34-7453 Usual Residence of Dacedent	7. Age	58	Yrs. If Under 1 Year Months Days		8. Date of Bir (Month, Da June 1	th 1y, Year) 0,1939	9. Birthple Countr Mar	ce (State or Foreign y) 'y land	
hours effer death with the Manyland hours effer death with the Manyland ural, or fleme 23e or 28e-f ehow at Example must be notified at	_	10a. State 10b. County		10c. City, To	vn or Location				100	d. Inside City Limits	
8 P. M.	Director	Maryland Washington			Hagerstown	<u> </u>			1 X 0√es 2□i		
or 2	급	10e. Street and Number			10f. Zip Code			10g. Citizen of	of What Country?		
ath v	ra	202 E. Franklin St.				740		U:	SA		
er de	Funeral	Arme	Decedent E ed Forces?		13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yas or No Rican, etc.)	- 14. Rac Blac	e - Amarica ck, White, et	n Indian, c.	
s of	by F	MYe	s, Give	• 1958-	1 ☐ Yes 2X No	Specify:		Specify	. Whi	te	
72 hours natural,		15. Decedant's Education	r or Dates:	1961	a. Decedent's Usual Occu	matica		10-14-1-10			
d within 72 hours of glone. In then "natural", or the Medical Evan	Completed	(Specify only highest grada comple			(Give kind of work done life. DO NOT use retire	during most of work	ring	16b. Kind of B	usiness/indu	istry	
l within lene. then	E	Elementary/Secondary (0-12) Colle	ege (1-4or 5-	+)	Owner/Oper	,		Tay	vern		
be filed htal Hygi d other event,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,				
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	To B	Charles Blucker	Potts			Florence	e Viola	Crist			
d 2 should be file th and Mental Hy 7 is merked othe traumatic event,	-	19a. Informant's Name/Relationship (Type, Print	1)	19	b. Mailing Address (Stree				State. Zip C	Code)	
C - W L		Joni Britner/Daughte			7051 Sterli						
- 455		20a. Method of Disposition			of Disposition (Name of ary, crematory or other pla		Date	20c. Location -			
8-25		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	from State			1					
nit. Pe vartmen ortant: Injury	-	21. Signature of Ineral Service Licenses		Green	awn Memoria			Willian	nsport	,Maryland	
Depa Impo any l		·///: //// ///				ess of Facility Funeral Ho					
		1/1/901/11. WM-			425 S. Con	ococheagu	e St.Wi	Iliamspo			
		Part1. Epter the disease, or complications t shock, of heart failure. List only one cause	on each lin	ine death. Do e.	not enter the mode of dy	ing, such as cardiac	or respiratory a	rrest,	1 1	Approximate nterval Between Onset and Death	
Physician /Medical		Immediate Cause (Final				/				onset and Death	
Examiner		disease or condition rasulting in death) a.	Co	Hore	ung occi	usevi				Udden	
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nsit	Examiner	b	a	tuces	3 derotic	Q1500	20			KOLJ	
axect n and el-tra	Xai	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying									
ficete be ex physician is the buriel	-e	Cause. Enter Underlying Cause (Disease or injury that initiated events									
fficete be executed g physician and as the bunel-transit	edical	resulting in death) Last	D	ue to (or as a	consequence of):						
	-	d									
eath cert ettendin for use	Clar										
that the death cer ed by the ettendir deteched for use	Physician/N	Part II. Other significant conditions contributing	to death but	not resulting	n the underlying cause gi	ven in Part I.				he cause of death?	
							10	Yes 2 No	3 Proba	bly 4 ☐ Unknow	
8 5 6	d by						24a Was	an autopsy	24b. Were	autopsy findings	
v require been si	Completed							med?	avail	able prior to pletion of ceusa	
The law ate hes b page 2 s	E								of de	ath?	
							101	res 25 No	10	Yes 2□ No	
delar	m	25. Was cese referred to medicel examiner?			Ot	26. Place of Death					
<u> </u>	2	195 2 NO	1 Inpatien		Itpatient 3LJ DOA	4 LI Nursing Ho	-	dence 6 Oth			
After fune	tlon	Natural 5 Pending	Date of Injury Month, Day	Year)	Injury Wo	rk? Yes 2 No	Zou. Describe i	low injury occur	90		
death death stor:	Certification:	3 Suicide 6 Could not be 390 €	Dago of Injur	At home 6			20f Location //	Street and Alumb	as as Dural I	Zouto Atumbas	
or A efter Direct in by	Ta	4 Homicide determined	uilding, etc.	(Specify)	arm, street, factory, office		City or Tov	Street and Numb vn, State)	er or murai r	noute Number,	
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ithin omple		29b. Signature and title of contiller	manner state	9 u .	29c I Icen	se number		29d. Date signed	1 (Month De	Vans)	
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	-	NWWede Bo	K.		()1	1466		Junes	1000		
		30. Name and address of person who completed	cause of dea	ath (Item 23a) سر	(Type, Print) (Type, Print) (Type, Print)	a. A	Haves	157	1.0		
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Stat		31. Date filed (Month, Paly Yen) 5 1000 3	12 Banine	& Signature							



State of Maryland / Department of Health and Mental Hygiene O 11.20

Item	5 per FH G762 8/11/98 EW	(Certificate	of Death	Re	eg. No.	. 1433	
Physician	Decedent's Name (First, Middle, Last) ROGER WI	LLIAM	PRIC	HARD	2. Date of Death Month JUNE	Day 1998	3. Time of Deeth 10:40 A.M	
/Medical Examiner	4a Fecility Neme (If not institution, give street and numb #6 ENSIGN DR.			4b. City, Town, or I	ocation of Deeth	4c. County of Do	eeth	
Funeral Director		Age (In yrs. last birth	Months D	Year If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, DEC . 19,	Year) 9. E	Birthplece (State or Foreign Country) MARYLAND	
ahow det	Usuai Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits 1 ☐ Yes 2 1 No	
dical Exercises must be notified at eted by Funeral Director	MD WORCESTER 10e. Street and Number		10f. Zip Co	BERLIN de	10	10g. Citizen of What Country?		
hatural, or from 23a or 28a-f show adeal Exercine must be notified at leted by Funeral Director	# 6 ENSIGN DR. 11. Meritel Status 12. Wes Deced Armed Force	es?	13. Wes Deceden If Yes, specify	21811 of Hispanic Origin? (S Cuben, Mexicen, Puert	pecify Yes or No- o Ricen, etc.)	U.S.A. y Yes or No- len, etc.) 14. Race - American I Bieck, White, etc.		
LEXENS d by F	1 Never Merried 2 Married 1 Yes 2 If Yes, Give Year or Date	es:	1 ☐ Yes 2 🖔				WHITE	
aumatic event, the Medical I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4)	or 5+)		ccupetion fone during most of wor etired)	king	U.S. POST		
other traumatic event, the Ma	17. Father's Name (First, Middle, Last)		IODIAL I		ne (First, Middle, A		011202	
70	WALTER	PRICHAR		FLORE			OLSON	
rtraur	19a. Informant's Name/Relationship (Type, Print) SHARON LYNN LANDIS - DA			treet and Number or Au TEAGUE RD.		, MD 2181		
	20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	20b. Piace of I	Disposition (Name , crematory or othe	of	Date :	20c. Location - City		
any injury or	21. Signature of Funeral Service Licensee	. OFSP	22. Name and A	ddress of Facility FUNERAL HON	705	E. MAIN S	ST.	
Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertrying Cause (Disease or injury that initiated events resulting in death) Lasf	Due to (or as a co	onsequence of):	Libetes	ye			
signed by the attending do be deteched for use a d by Physician/M	Part II. Other significant conditions contributing to dea	th but not resulting in	the underlying caus	e given In Pert I.	23b. Dld to	bacco usa contrib	ute to the cause of death?	
be detech by Phy					1 🗆 Y	●8 2□ No 3□	Probably 4 Onknown	
shoul					24a. Was a perform		lb. Were eutopsy findings available prior to completion of cause of death?	
Com					1 □ Ye	es 20 No	1 ☐ Yes 2 1 10	
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	i uprvatorar 5 🗀 i dirigi	Injury 28b. Ti		Other:		enca 6 Other (Sow injury occurred	Specity)	
led in by the funeral Certification:		Injury - At home, fam , etc. (Specify)			28f. Location (St City or Town		r Rural Route Number,	
To the Funeral Director: After completely filled in by the funer Medical Certification	29a. Certifier (Check only one) Check only one) Check only one) Certifying Phyelcian: To the bear and manner.	is of examination and	death occurred at t /or investigation, in	he time, date and place my opinion, deeth occu	, end due to the co rred et the time, d	euse(s) end manne ate and placa, and	r as etated. due to the ceuse(s)	
Toth	29b. Signature and title of certifier	m	29c. L	0-35764	2	9d. Date signed (M	lonth, Day, Year)	
12	30. Name and address of person who completed cause	of deeth (Item 23e) (1	Type, Print) (AAA S	t. Ber	lin, N	d. 2	1811	
State	31. Date filed (Month, Day, Year) 32, Res	platrar's Gigneture	64		,			

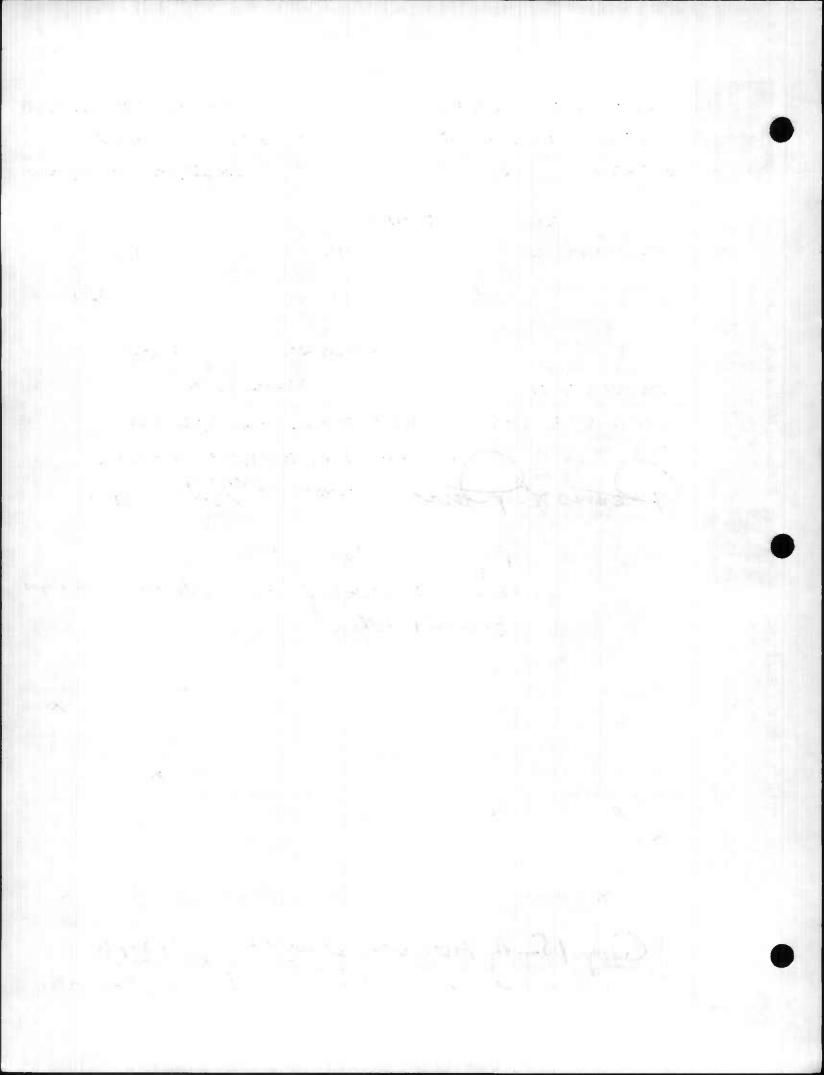


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 29, Irene 1998 12:33 AM **GLADYS** RUDISILL JUNE /Medical 4a Facility Name (If not institution, give straet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) Sept. 18, 1920 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sax **Funeral** Months Hours Min 1□ M 21 F Days Pennsylvania 204-03-3755 77 Director Usual Residence of Deceden the Maryland 10d. Inside City Limits 10c City Town or Location 10a State 10b County Pages 1 and 2 should be filed within 72 hours after death with the Marylan neart of Health and Mentat thyglene.
Int: If item 27 is marked other than "naturel", or items 23s or 28s-f show that if item 27 is marked other than "naturel", or other traumatic event, he lead as Examinat man be not listed. 1 N Yes 2 □ No Director Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 990 Waterford Dr. 21702 U.S.A. Funeral 12. Was Decedent Evar In U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ Xlo Specify: White Specify: ò 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Nursing Ass. Hospital 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Florence M. Izer John Wesley Nowell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 to Department of Health ar important: If item 27 is any injury or other traughts. D. Edwin Rudisill (Son) 8401 William Dr. Frederick, Md. 21701 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State W Burial 2 ☐ Cremation 3 ☐ Removal from Rest Haven Cemetery July 1,1998 Hagerstown, Md. 5 Other (Specify) 22. Name and Address of Facility ignature of Faneral Service Licensee 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Daath **Physician** /Medical Immediete Cause (Final RESPIRATORY disaasa or condition resulting in deeth) Examiner Examiner pulmonally disease ician and burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last physician s the burial P.O. Box 68760, DRONChia Physician/Medical use as I 23b. Did tobacco use contributa to the causa of death? been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yss 2 ☐ No Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy parformed? Completed page 2 22 No 1 ☐ Yes 2 ☐ No 1 □ Yas certificate Hospital or Attending Physician: funeral director, 25. Was cese referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 2 1 SInpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeret Di completely filled in Csrtifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and menner es stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 VICE PRESIDENT who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person FREDERKY itose: FREDERICK MEM. SMITH 31. Dete filed (Month, gay Year) I 1998 32. Registrer's Signature

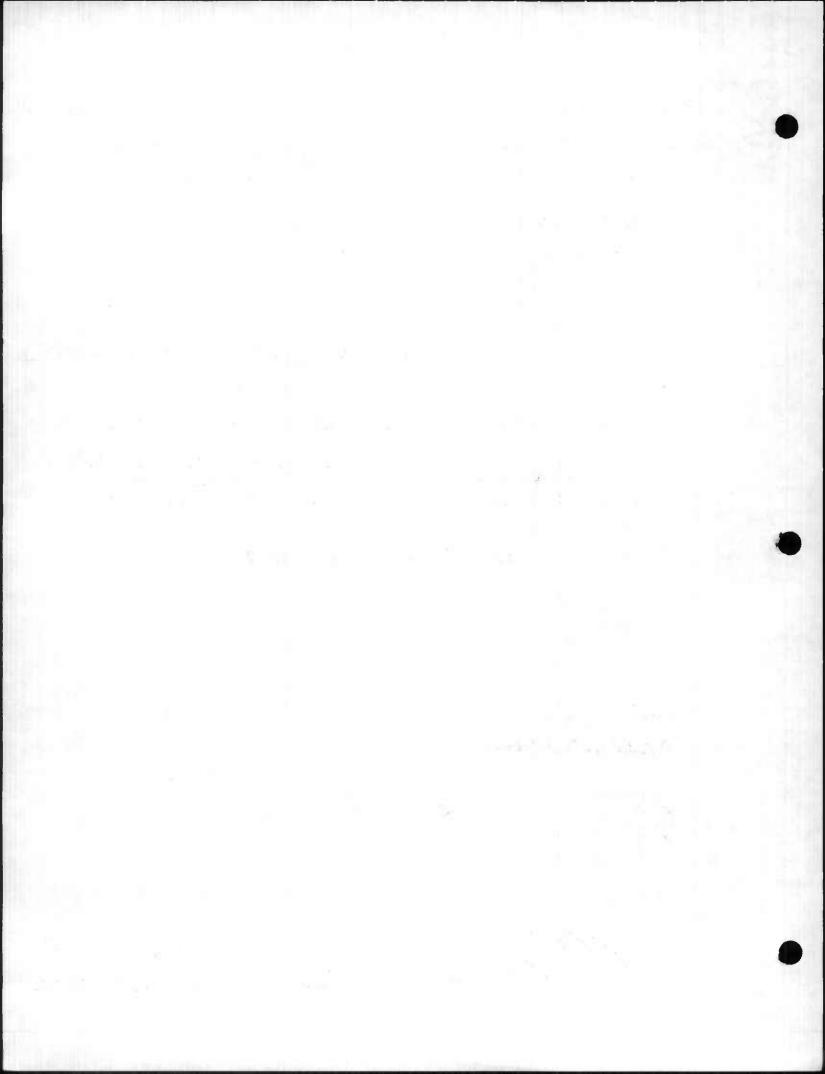
Junia Davidson-Randelle State

Registrar



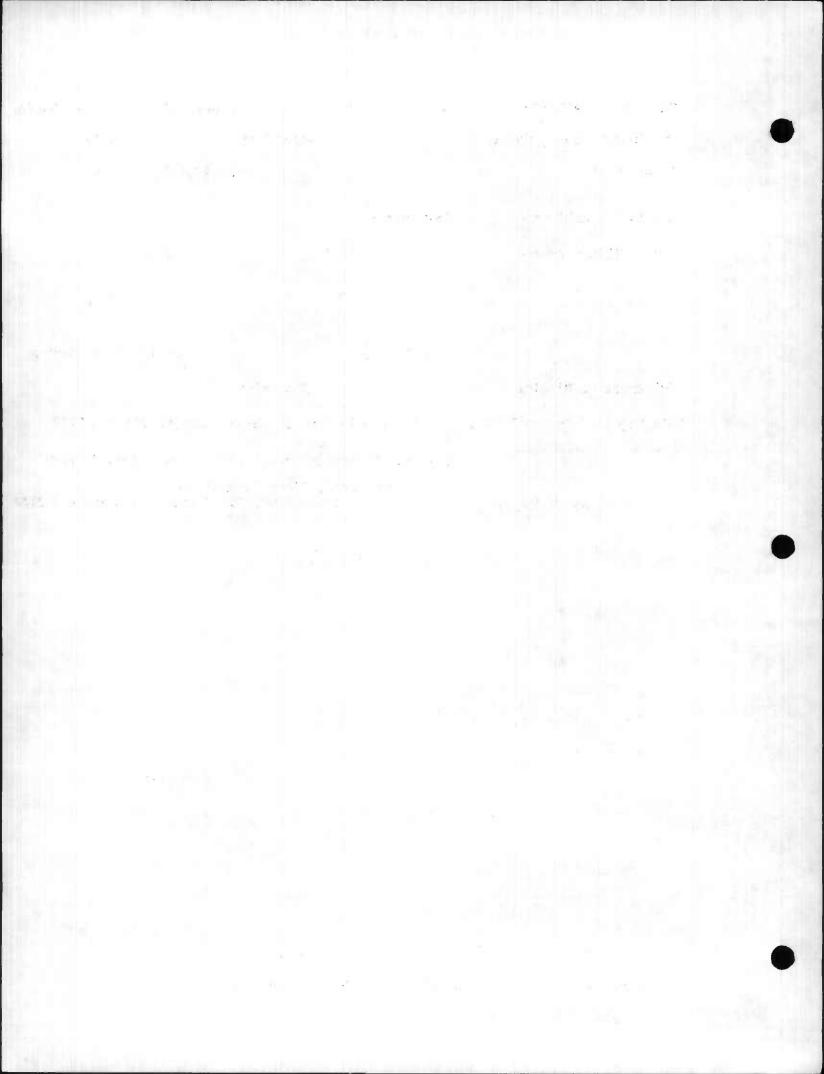
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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П	Physici	an	1. Decedent's Neme (First, Middle,					2. Data of D Month	Dav	998°	3. Time of Death					
J.	/Medi	cai	DAWN MARIE ROHRE 4a. Facility Name (If not institution,				4h City Town	JUNE			12:52 P.M					
и	Examir	ner	WASHINGTON COUNT								DAT					
Н	Funeral	П		S. Sax 7. Ag	je (in yrs. last b		ear If Under 24			9. Birthple	JIN aca (Stata or Foreign ry)					
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	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	vn or Location				10	d. inside City Limits					
	hours after death with the Maryland turel', or items 23a or 28a-f show at Examinet must be notified at	tor	MARYLAND WASHIN	GTON	BOON	ISBORO					1 ☐ Yes 2 ☐ No					
	or 28s	Director	10e. Street and Number	02021	2001	10f. Zip Cod	е		10g. Citizan of	What Count	ry?					
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	after deal	Funeral	11. Maritai Status	12. Was Dacedent Armed Forces?		13. Was Decedent if Yes, specify C	of Hispanic Origin Juban, Mexican, F	n? (Specify Yas or N Puerto Rican, atc.)	lo- 14. Ra	ca - America						
20	be filed within 72 hours after des viel Hygiane. Id other than "natural", or frems event, tra Modical Examination	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X if Yes, Give Year or Dates:	No	1 □ Yes 2 1	No Specify:		Specia	Specify:						
21215-0020	"natural",		15. Decedent's	Education	168	ı. Decedent's Usuai Oc	cupetion		16b. Kind of B	WHI]						
215	filed within 72 Hygiane. Ither than "natem, and the file than "natem, and the file file file file file file file fil	Completed	(Specify only highast Elementary/Secondary (0-12)	grade completed) College (1-4or t	5+)	(Give kind of work do life. DO NOT use re	ne during most o tired)	f working			·					
	e filed wi al Hygian other th		12 YEARS			SABLED-NEV				-	ER EMPLOYED					
anc		Be	17. Father's Name (First, Middle, La	ist)				Name (First, Middl		ne)						
Maryland	s 1 and 2 should by f Heelth and Mente ftem 27 is marked other traumatic ev	2	EDWARD L. ROHRER 19a. Informant's Name/Reletionship	(Type Print)	19	b. Mailing Address (Str		E L. REES	_	State 7in (Code					
	C/ cg 20 50		EDWARD L. ROHRER			313 MAPLEVI					21713					
ore,	of He of Her		20a. Method of Disposition	-		of Disposition (Name or ery, crematory or other		Data	20c. Location							
Ē	Pages ment of I ant: if ite ury or o		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			ORO CEMETE		3/98	BOONSBO	RO. MA	ARYLAND					
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	To the Hospital or Attending I within 24 hours after deeth. To the Funeral Director: After complataly filled in by the funer		29a. Certifier 1 Certifying I	Physician: To the best of	of my knowledg	e, death occurred at the	time, date and p	place, and due to the	a cause(s) and m	anner as sta	ited.					
	the Ho nin 24 the Fu	edical	(IN)	aminer: On the basis of end manner sta	exemination arated.	nd/or investigetion, in m	y opinion, deeth	occurred at the time	, date and place,	and due to t	the cause(s)					
	To To Foo	Σ	29b. Signature and titla of certific				29c. Licanse number 29d. Date signed (Month, Day, Year) DZ6 F06 Tune 17, 1988 Print) And Hyertern 21742									
			111	//			16 80	6	June	17,	1770					
			30. Name and address of person wh	completed cause of d	eath (Item 23e)	(Type, Print)	0	Henry	10000	1.0	21243					
	Sta	te	31. Dete filed (Month, Day, Year)	110	ar's Signature	Bud on	+ue	reges	- carry	WJ	-1/12					
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			State of Ma		partment of Fertificate of			giene 98 Reg. No.	2	1442
	Dhualaian	1. Decedent's Neme (First, Middle, Las	t)				2. Data of Dea		Year	3. Tima of Death
	Physician /Medical	MARGARET KATHER	INE RIN	GLER			June	. 15 19	198	5:45 Pm
	Examiner	4e Fecility Nama (If not institution, giva Washington County				4b. City, Town, or Lo Hagerstov		Washi		on
Т	Funeral	Social Security Number 6. Se	7 4 4 - POV	a (In yrs. last birthda	y) If Undar 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Birt (Month, Da	v. Year)	9. Birthple Count	ece (State or Foreign
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	land	Usual Residence of Dacedant 10a. Stata 10b. County		10c. City, Town or	Location				10	Od. fnslda City Limits
	Man,	Maryland Washing	rton	Hagerst	own					1 ☐ Yas 2X No
	or 28	10e. Street end Number			10f. Zip Coda			10g. Citizen of W	hat Count	ry?
	ath w	20021 Tillman Ave			21742	Variable Orlands (On		U.S.A.	Amariae	a ladian
020	72 hours after death with the Maryland natural, or terms 23a or 28a-f show deat Examiner must be notified at each by Funeral Director	11. Maritel Status 1 ★ Navar Marriad 2 ★ Married 3 ★ Widowed 4 ★ Divorced	12. Was Dacadent E Armed Forces? 1 Yas 2 N If Yas, Give Yaar or Datas:		3. Was Dacedant of I If Yas, specify Cub 1 ☐ Yas 2 ☒ No	Rican, atc.)	Bleck	- Amarica k, Whita, e	etc.	
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land	Sage W	Sylvester K. Ring	ıler			Ida Smit				
Maryland 21215-0020	and Men and Men aumeric	19e. Informant's Name/Relationship (7		19b. Ma	iling Address (Street			er, City or Town, S	Stete, Zip	Coda)
	1 and 2 Health em 27 le other tra	Lois Leggett/ Pers	sonal Rep.		07 Lois St	treet Ha	-	vn, Maryla		21742
Baltimore,	Pages 1 nent of H rrt: If Ren rry or oth	20a. Mathod of Disposition 1 → Burlal 2 → Cramation 3 →	Ramoval from Stata	cemetary, ca	position (Nama of ramatory or othar pla		Date	20c. Location - 0		
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Ba	permit. Departr Imports any inj anse	21. Signature of Funeral Service Licens	see		22. Neme end Addre Douglas A	. Fiery F				
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8760,	physician a tha burial	Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or Injury	C				_			
687	the the	that initieted events rasulting in death) Last		Due to (or as a cons	equance of):					
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	death certific a attending p od for use as sician/Me	Part II. Other significant conditions co	ntributing to death bu	ut not rasulting in the	undarlying cause gi	ven in Part I.	23b. Dfd	tobacco usa con	tributa to	the cause of death?
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no	tending Ph leath. tor: Attar th the funaral cation: 7	27. Mannar of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accidant investigation	(Month, Da)	Year) Injury	, Wo	rk? Yes 2 No	Zou. Describe	now injury occurr	50	
Division	or At office or At in by	3 Suicida 8 Could not be datermined		ury - At homa, farm, c. (Specify)	streat, fectory, office		28f. Location (City or To	Street and Numbe wn, Stata)	er or Rura	l Routa Number,
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	within To the comple	29b. Signatura end title of certifier			29c. Lican	sa number		29d. Dete signed	(Month, I	Day, Year)
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		30. Neme and address of person who o					7 .	04740		
	CATA	Dr. Edson Moody 31. Data filed (Month, Day, Year)	32. Registra	t. Aetna	Koac Hage	erstown,Ma	aryland	21740		
	State Registrar	JUN 16 199	18 Julia	Davidson-A	andell					

DHMH 16 Rev 6/95



CHARLES SETTLEMYER	ITEMS:	#23			State of Maryland / Department II, 27,28A-F PER MEO Certificate	
	. Decedent's I	Neme (First, Mid	dle. L	ast)	

Health and Mental Hygiene Death Reg. No.

Birthplece (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of deeth?

1 OCYAS 2 No

1 Yes 2 No

*
Physician
/Medical
Examiner

4e Fecility Name (If not Institution, give street and number)

William

Charles

Settlemyer

2. Date of Death 3. Time of Death Month JULY 04, 1998 8:55P.M.

China

Black, White, etc.

White

Funeral Director

Director

Funeral

à

Completed

the Maryland 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner mant be notified at

death Pages 1 and 2 should be filed within 72 hours after of thealth and Mental Hygiene.
nt: If item 27 Is marked other than "natural", or ites other Department of Important: If any injury or injury or

Maryland 21215-0020

Saltimore,

Physician /Medical

Examiner

Physician/Medical

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94 12 917 P.0 8 6 peudis Division of Vital Records. 8 564 page 2 certificate 100 funorul Anshding death. after deal

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24 hours Hospital

To the Hosp within 24 ho To the Fune completely fi

4b. City, Town, or Location of Deeth 4c. County of Death CHARLOTTE HALL VETERANS HOSPITAL CHARLOTTE HALL ST.MARYS If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yeer 5 Social Security Number 7. Age (In yrs. last birthday) 10 M 20 F Months Days 294-01-0358 80 Yrs. July 8, 1917 Usual Residence of Decedent 10b. County 10c. City, Town or Location Maryland Prince George's Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6315 Middleton Lane U.S.A.

14. Reca - American Indian, 20748 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 20No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Federal Government Statistician 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Edna Eva Kurz Charles Spurgeon Settlemyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6315 Middleton Lane Temple Hills MD 20748 Jean Settlemyer (Wife) 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 20 Cremation 3 Removal from State 4 Donation 5 Other (Specify) July 8, 1998 Clinton, Maryland Lee Crematory 22. Name end Address of Facility Lee Funeral Home, Inc. 20735 21. Signature of uneral Sevices ice 6633 Old Alexandria Ferry Rd Clinton, Maryland ease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, e. List only one cause on each line. immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): CHRONIC LEG ULCERS Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as e consequence of): 23b. Did tobacco use contributa to the cause of death? Part #. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ALZHEIMER'S DISEASE HYPOTHYROIDISM 24a, Was an autopsy performed?

> 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Dey Year) 5 Pending UNKNOWN investigation 6 Could not be determined

28b. Time of UNKNOWN

28c. Injury at Work? 1 ☐ Yes 2 X No 28d. Describe how Injury occurred PRESSURE FROM RESTRAINTS

15 Yes 2□No

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
NURSING HOME 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 29449 CHARLOTTE HALL RD. CHARLOTTE HALL, MD

JULY 7,1998

29b. Signature and title of cartifier

25. Was case referred to medical

1 X Yes 2 □ No

27. Manner of Death

1 Natural

2 X Accident

3 Sulcide

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year)

30. Name and address of person when completed cause of death (Item 23a) (Type, Print)

hute ho

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Dennis 31. Date filed (Month, Dey Dey, Year) 13

32. Registrar's Signature whie Davidson State of Maryland / Department of Health and Mental Hygiene 🧻 🖟

				Otate of Maryle		Certificate				Reg. No.	0 21	444				
	Physici	an	1. Decedent's Name (First, Middla, Last) Julia El	izabeth SHO	CKEY				2. Deta of De Month	Day	Year 98	Time of Deeth				
	/Medi Examir	cal	4e. Facility Nema (If not Institution, give s		OKEL		46	. City, Town, or L	June .ocation of Death							
1	Examin	iei	Williamsport Nurs					Williams			hingtor	n				
i i	Funerai Director		5. Social Security Number 6. Sax 267-46-7285	7. Aga (In y		thday) If Under 1 Months	Yeer Days	If Under 24 Hrs. Hours Min.	8. Dete of Bird (Month, Da August	y. 7°,1904	9. Birthplace County) Mary la	(Stata or Foreign nd				
	/land		10a. Stata 10b. County	10c.	City, Town	n or Location					10d. ir	nside City Limits				
	a-f sh	tor	Maryland Washingt	on	Hage	erstown					1	XXYes 2 □ No				
	th with the 23e or 28	al Director	10e. Street and Number 538 West Wilson Bl	vd.		10f. Zip C		21740		10g. Citizen of V U.S						
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show styling or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 1 □ Nevar Married 2 □ Married 3 □ Widowed 4 △ Divorced	Was Decedant Ever in Armed Forces? □ Yes 2 ☑ No If Yas, Giva Yaar or Datas:	U,S.	13. Was Deceda If Yas, specif			pecify Yes or No Rican, atc.)	Specify	e - Amaricen Inck, Whita, atc. whi					
5-0	72 h	eted	15. Decedant's Educ (Specify only highest grade	cetion completed)	16a.	Decedent's Usuel (Giva kind of work lifa. DO NOT usa	Occupat	tion uring most of work	king	16b. Kind of Bu	usinass/Industr	у				
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yla	Menta Menta mrked	To E	Tryon	Braguni					Annie	Rice						
Maryland	d2sh thand 7 is m traum		19e. Informant's Name/Raiationship (Tyx) Mrs. Virginia Eshe			Meiling Addrass (24 Marsh						*				
re,	f Heel frem 2 other		20a. Method of Disposition	200	. Piece of	Disposition (Name y, crematory or oth	a of		Data	20c. Location -						
E	Page nent o ant: If any or		1 ☐ Burial 2 ☐ Cramation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State		Hill Ceme			June 30,1998	Hagers	town, M	aryland				
Baltimore,	Departr Departr Imports eny ink		21. Signatura of Funaral Sarvice Licensea 22. Name end Address of Feclify Minnich Funeral Home													
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	pe list	Examiner	6. Diabetes													
Ć	tificate be executed g physician and as the buriel-transit	Exar	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avants			consequance of):	4 ~				1					
68760,	ate be nysicia he bur	edical	Causa (Disease or Injury that initiated avants rasulting in death) Last	Atherosch		consequence of):	TD	152ase			Y	ears				
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o.	by the	hysi	Part II. Other significant conditions conf	-	_	•	use giver	n in Perti.		Yes 2 No		cause of death? 4 □ Unknown				
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Division of Vital Records, P.O. Box	The law requires that the death certific ate has been signed by the ettending p page 2 should be detached for use as	Completed	Hypertension Congestive Hear Right above kn	+ Failure					24a. Was perfo	an autopsy ermed?	availabi	utopsy findings ia prior to tion of cause n?				
<u> </u>	sician: The law certificate has t lirector, page 2 s		Kight above kn	ee ampu	tat	con			10	Yas 2000	1 🗆 Yas	s 2 No				
X	Attending Physician: or death. ector: After this certific by the funeral director,	o Be	axaminar?	osnitei:			Other	26. Place of Daa								
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Ω	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this cartificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicida 6 ☐ Could not be datamined	28a. Place of Injury - A building, atc. (Spe	homa, fa	m, streat, factory,	office		28f. Location (3 City or Tox	Street end Numb vn, Steta)	per or Rural Rou	uta Number,				
	Hosp 24 hou Funer stely fill	edical	29a. Cartifier 1 Certifying Physic (Check only one) 2 Medicat Examin	cian: To the best of my ker: On the basis of examinand manner steted.	nowledga netion and	, daath occurred at Vor invastigation, in	t the time in my opi	a, data and piace, nion, deeth occur	and dua to tha rred et the time,	causa(s) and ma dete end ptece,	annar as stated and dua to tha	ceuse(s)				
	ro the vithin romple	Mec	29b. Signatura and titla of certifier 29c. License number 29d. Dete signed (Mor								d (Month, Dey,	Year)				
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			30. Name and address of person who core Cynthia Kuther - S 31. Data filed (Month Day Year)	ands mp 111	10 17	redical C	amp	ous Kd.	Hager	> TOWN,	rice. y lac	na .				
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State of Maryland / Department of Health and Mental Hygiene \

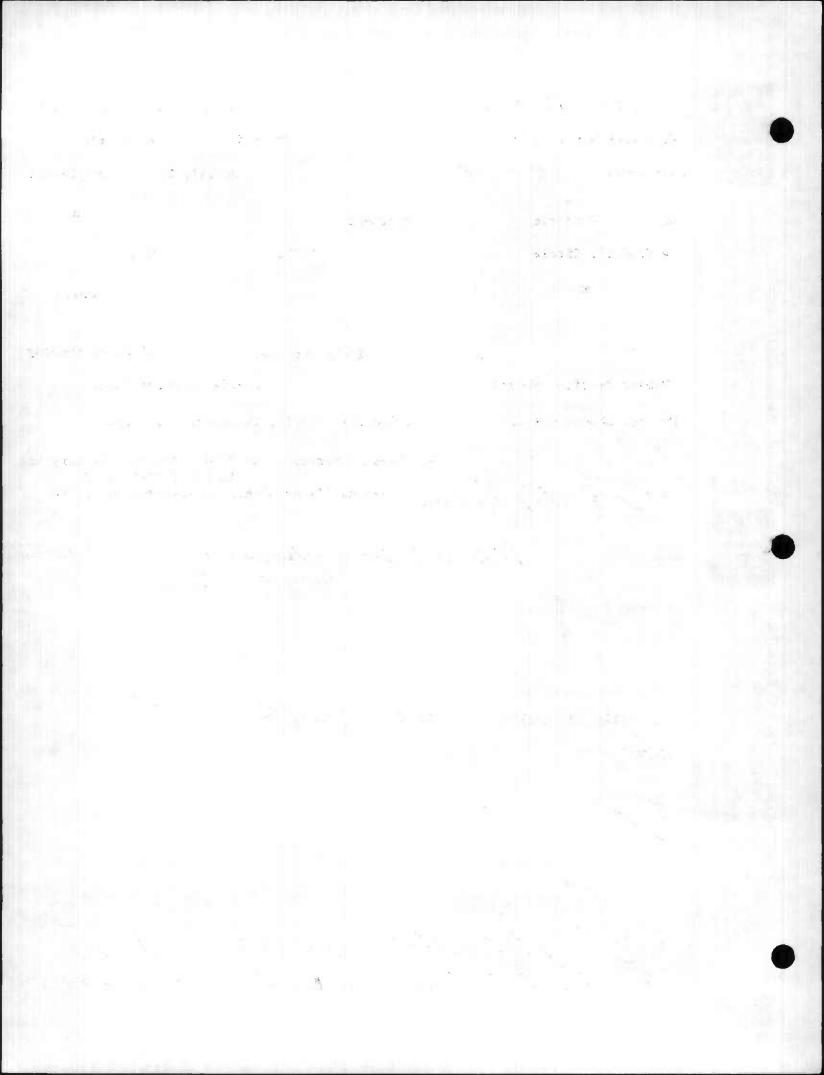
Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month **Physician** Joseph Small Shuman 24, 1998 6:55 P.M. June /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Min. Deys Hours 1⊠M 2□F Months 214-09-8828 81 Director Oct.17,1916 Pennsylvania Usuel Residence of Dacedani death with the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits re 23a or 28a-f show 1 XX Yas 2 □ No Director MD Frederick Thurmont. 10g. Citizen of Whet Country? 10f. Zip Code 10e Street and Number 4 Goodwill Circle 21788 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Reca - Amarican Indian, Black, Whita, atc. r than "natural", or items the Medical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yas 2 No 1 □ Navar Marriad 200 Marriad altimore, Maryland 21215-0020 1 ☐ Yas 2 K No Specify: Specify white 2 3 Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiane. Elamentary/Secondary (0-12) Collaga (1-4or 5+) telephone company 12 O field engineer 7 is marked other traumatic avent, 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health end Mental Robert Pattison Shuman Lizzie Burnside Small 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) nt of Health e If Itam 27 is or other tra Frances Shuman - wife 4 Goodwill Circle, Thurmont, Md. 21788 20b. Pleca of Disposition (Neme of cemetary, cremetory or other plece) 20e Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stata Department of Important: If any Injury or page. Rest Haven Cemetery 4 Donetion 5 Other (Specify) 6-27-98 Hagerstown, Maryland 21. Signature of Euweral Service License 22. Name end Address of Fecility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 unsed Approximeta Interval Between Onsat and Death 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disaasa or condition resulting in deeth) Examiner Carcinoma primary Examiner The law requires that the death certificeta be axecuted attending physician end for use as the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Ceuse (Disease or trijury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequença of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wera autopsy findings available prior to complation of causa of deeth? Completed 24a. Wes en eutopsy ancer performed' paga 2 1 T Yes 2 FINO 1 ☐ Yas 2 ☐ No cartificate Hospital or Attending Physician: funeral director, Be 25. Wes case referred to medical 26. Pleca of Death (Check only one) axaminer Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Lo 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Menner of Deeth 28e. Date of tnjury (Month, Dey Year) Certification: 28b. Time of 28d. Dascribe how injury occurred 28c. tnjury et Work? After 1_ Natural 5 Pending s after death. 2 No Investigation 1 Yes 2 Accident 3 Suicide 8 Could not be determined Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Streat end Number or Rurel Routa Number, City or Town, Stete) filled in by 4 \(\text{Homicide} \) To the Hospital of within 24 hours a To the Funeral D completaly filled in the Funeral D completaly filled in the Funeral D completal filled in the Funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled in the funeral D completal filled i Certifying Physician: To the best of my knowledga, death occurred at tha tima, date end place, end due to the ceuse(s) and mannar as stated.

2 Medical Examinar: On the best of examinetion end/or threstigetion, in my opinion, deeth occurred at tha tima, data and placa, and due to the cause(s) end menner stated. edical 29a. Cartifiar (Check only one) 29b. Signeture en fitte of certifie 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Neme and address of perso o completed cause of death (Item 23e) (Type, Print) W. 9th st Frederick MD 600 31. Dete fited (Month, Day, Year) 32. Ragistra's Signature

wie Davidson-Randoll

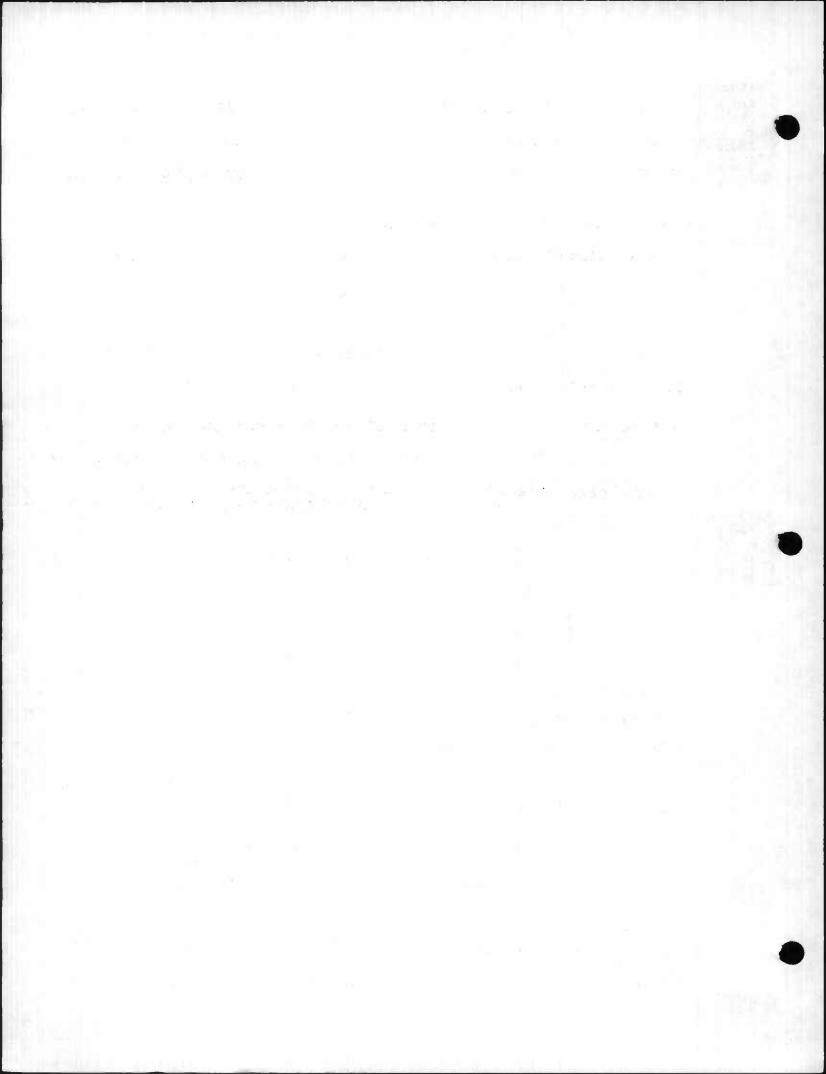
State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

							Cei	rtificat	te of	Death			Reg. No.			
			1. Decedant's Nama (First, M.	ddia, Last)								2. Data of De	eeth	V. in	3. Tim	a of Death
	Physic /Med		ADALINE	ARMATHA	SWE	ENEY						Month 06	Day 21	98	02	20
Ť	Exami		4a. Facility Name (If not institu	tion, give street and	number)					4b. City, To	wn, or L	ocation ot Deal	th 4c. Count	y of Death		
			WASHINGTON	COUNTY HO	SPITA	AL				HAC	GERS'	TOWN	WA	SHING	TON	
	Funeral	г	5. Social Security Number	6. Sax	7. Aga	(In yrs. last	birthday)		r 1 Yaar	If Under	24 Hrs.	8. Date of Bi	rth			te or Foreign
П	Director		214-09-7209	1□ M 2√		82	Yrs.	Months	Days	Hours	Min.	MAY 14	ay, Year)	Cour M A R	VI AN	te or Foreign
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	yland		10a. Stata 10b. Cou	nty		10c. City, To	own or Lo	cation						1	10d. Insid	a City Limits
	Mar Mar	to	MARYLAND WAS	HINGTON		НΔ	GERS'	TOWN							1,01	Yas 2∏No
	the 28s	Directo	10e. Street and Number	1121101011			OLITO	10f. Zip	o Coda				10g. Citizen of	What Cour	ntry?	
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	Jeath Tra 2	Funeral	11. Marital Status	12. Was D	ecedant E	var in U,S.	13. \			Hispanic Orl	lain? (So	ecify Yes or No		ce - Americ	can Indiar	1.
_	r Kee	Ē	1 □ Navar Married 2 □ N	Armad	Forcas?		- 1	f Yas, spe	cify Cub	an, Mexicar	n, Puerto	ecify Yes or No Rican, atc.)	Bia	ck, White,		
Maryland 21215-0020	72 hours after death with the Maryland natural, or items 23s or 28s-f show orce Examiner must be notified at	by	3 ☐(Widowed 4 ☐ Divor	It Yas,	Giva r Datas:		1	I □ Yas	2 XNo	Specify:			Speci	ty: WH	ITE	
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	71 5 1		GAIL L. HESS										L, CALI			5037
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Division of Vital Records,	aftar aftar Direction of in b	Certification:	4 ☐ Homicida Gate			ry - At homa, (Spacify)	,	,	,,			City or To	wn, Stata)			
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funa	Me	29b. Signature and title of cort										29d. Data signa	ad (Month.	Day, Yea	ir)
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			30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) WANTE UZI CANIN MO 19336 MEADINIVION DR. HARB								0 9 /					
			Su. regimen and account of pers	on who completed ca		eth (Item 236 MD) (Type, I	77	mi	AOM	11/18	Sul DE	O HA	RER	Cana	m.
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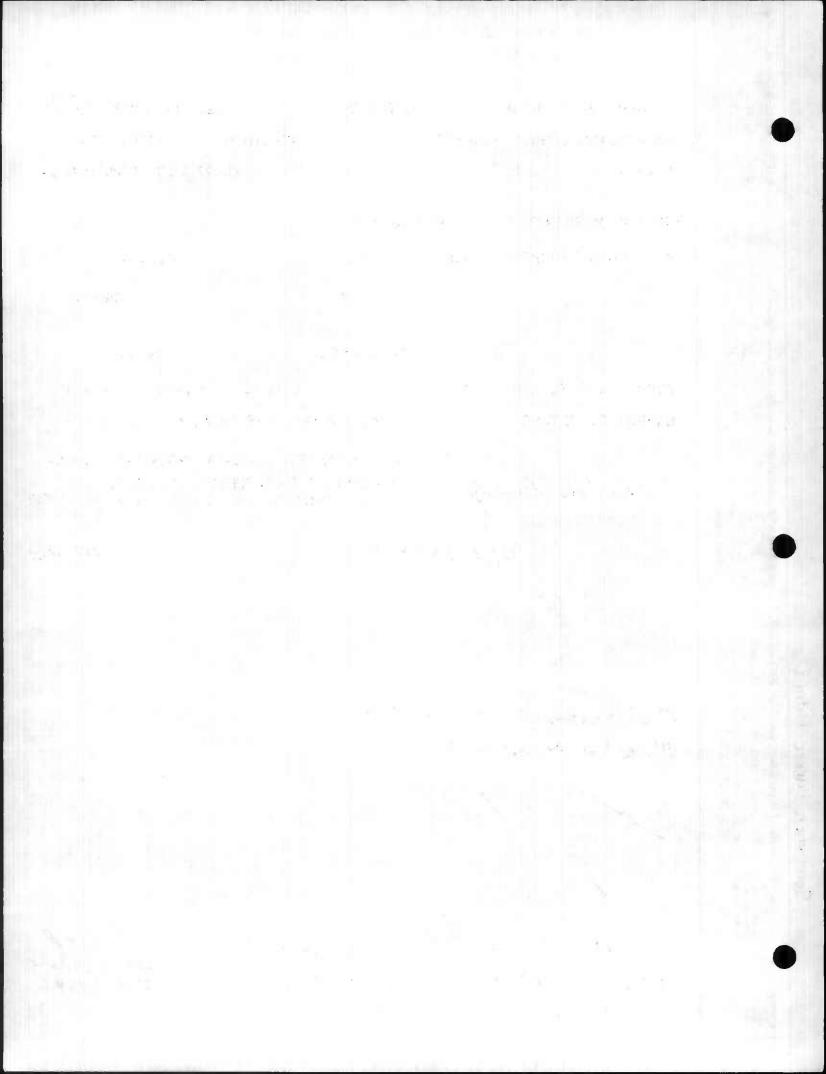


State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:20 PM CARRIE **JOSEPHINE** 1998 SOUTHWICK June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON H Under 1 Yaar H Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) NOV . 27, 1908 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 1 M & F 217-07-9790 Yrs. PENNSYLVANIA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglena.
Important: If Item 27 ie marked other than "natural" — any Injury or other treumetic events. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo MARYLAND WASHINGTON HAGERSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 241 SOUTH PROSPECT STREET 21740 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: WHITE þ 3 X Wildowed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN SAMUEL BITNER BLANCHE BREWER LILLIE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) HAROLD E. BITNER 1147 WOODLAND WAY, HAGERSTOWN, MARYLAND 21742 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ROSE HILL CEMETERY 06-22-98 HAGERSTOWN, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) ANDREW K. COFFMAN FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses R. noel 40 EAST ANTIETAM STREET, HAGERSTOWN, MD. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final diseasa or condition resulting in death) Prevnou /Medical 10 days **Examiner** Dua to (or as a consaquance of): Examiner physician and the burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical that initiated events resulting in death) Last Due to (or as a consequenca of) attending pl 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Ag 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed il director, paga 2. JNo 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case refarred to medical 26. Place of Death (Check only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Residenca 6 ☐ Other (Specify) 10 1 Yes 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient Aftar this 28a. Date of Injury (Month, Day Year) funaral 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? Certification: 5 Pending investigation 1 (2 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. (Specify) in 24 hour. the Funeral Directory 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29a, Certifier edical within 24 hou To the Fune complately fi 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Mghth, Day, Year) 29b. Signature and title of cartifier 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) neduald on Ry M (1116 DIDID 31. Date filed (Month, Day, Year) poistrar's Signature State Registrar

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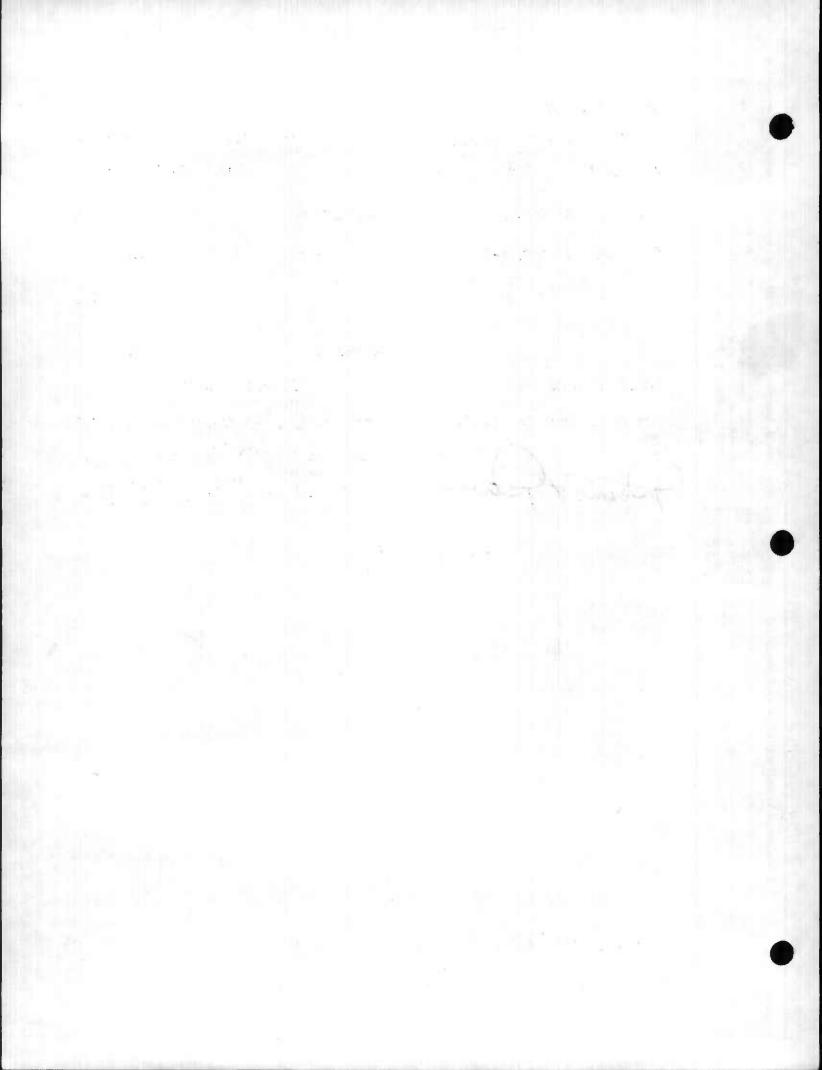
Southwick Carrie Bitney



State of Maryland / Department of Health and Mental Hygiene

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	Certificate of Death Reg. No.									
	1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death									
Physician /Medical	Rose Marie Swo	pe				June	Day	998	1:05 pu	
Examiner	4a Facility Name (If not Institution, give street and number)				4b. City, Town, or	Location of Death	4c. County of Death			
2.43.1111.0	Washington County Hospital				Hager	stown	Washington			
Funeral		Sex 7. Age ((In yrs. last birthday) If Under 1 Year If Under 24 Hr					lace (State or Foreign		
Director	214-46-5491			rs. Months Days Hours Min.		Nov. 3,	3,1938 Maryland		yland	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than *nature!, or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Usuai Residence of Decedent 10a, State 10b, County					10d. Inside City Limits				
	35.033	ington				town			M☐ Yes 2 ☐ N	
	10e. Street and Number			Hagerstown						
							10g. Citizen of Whet Country?			
	90 Manor Dr. Apt. A-3			21740			U.S.A.			
	11. Maritai Status	12. Was Decedent Eve Armed Forces?	er in U,S. 13.	13. Was Decedent of Hispanic Origin? (Spirit Yes, specify Cuban, Mexicen, Puerto		to Rican, etc.)		Black, Whita, etc.		
	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 Yes 2 No	Specia		in: White			
	15. Decedent's (Specify only highest g	Education rade completed)	16a. Decedent's Usuai (Give kind of work		one dunna most of working		16b. Kind of Business/Industry		dustry	
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	8 17. Father's Name (First, Middle, La:	nd)	П		-	me /First Middle	First, Middle, Maiden Sumeme)			
	Edgel L. Moore Sr.									
				Ethel L. Saud 9b. Meiling Address (Street end Number or Rural Route Nun						
	Mitchell F. Swox 20a. Method of Disposition	e Sr. (Husba	20h Place of Disc	Manor Ur.	. Apt. A-	-3 Hagers	town, Ind	City of To	740	
	Unial 2 ☐ Cremation 3	Removaling State	20b. Place of Disposition (Name of cometery, cremetory or other place) Pleasant Valley Cemetery			ino 23				
	Donation 5 Other (Spec					1998'	Smiths	burg,	Md.	
	22. Name and Address of Facility Davis Function 12525 Bradbury Ave.									
	Davis Funeral Home Smithsburg, Md. 21783 232 Part 1 Fater the disease or complications that caused the death. Do not enter the mode of thing, such as cardiac or resolvation agreet. Approximate							83		
Dec.	23a. Part1. Enter the disease, or co	mplications that caused th	e death. Do not er	nter the mode of dy	ing, such as cerdia	c or respiratory ar	rest,		Approximate Interval Between	
Physician									Onset and Death	
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aminer	resulting In death)	a. Du	a. Due to (or as e consequence of):						vage	
e e										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions.	■ b	b. Due to (or as a consequence of):							
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury									
	that initieted events resulting in death) Last	CDu	CDue to (or es a consequence of):							
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	examiner?	examiner? Hospital Cither:						ar /Snacil	60	
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	3 Suicide 6 Could not	28e. Place of Injury - At home, ferm, street, factory, office			28f. Location (Street and Number or Rural Route Number,			al Route Number,		
	4 Homicide	building, etc. (Specify) City or Town, State)								
	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner steted.									
	29b. Signeture, and title of chriffer 29c. License number 29d. Date signed (Month, Day, Year)							Dey, Year)		
	I MONTHER COLP 1 / colo UN				Nacobe			6/22/90		
	30. Name and address of person who completed ceuse of death (left) 23e) (Type, Print)									
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State Registrar	.IUN 25	1998 Fichia	Davidson-A	andelle						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Catherine Colista SHULL 1998 6:50 A.H. June /Medical 4c. County of Death 4a. Facility Neme (If not institution, give street end number) 4h. City Town, or Location of Death Examiner Williamsport Nursing Home Williamsport Washington 5. Sociel Security Number If Undar 1 Yaar If Under 24 Hrs. 7. Aga (In yrs. last birthdey) Birthpleca (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F 220-18-0305 87 Director Yrs. Pennsylvania Dec. 29, 1910 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Intropretari: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Example must be some. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA Linwood Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedant of Hispenic Origin? (Specify Yas or No It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Giva Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 XNo Specify: þ Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) aircraft laborer 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Meidan Sumame) Be Dennis Everts Sarah Gregory 19a. Intormant's Neme/Raietlonship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9329 Garis Shop Road, Hagerstown, Md. 21740 David L. Shull - son 20b. Piece of Disposition (Neme of cematary, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removei from Stata 6 - 17 - 984 ☐ Donetion 5 ☐ Other (Specify) Rose Hill Cemetery Hagerstown, Maryland 21. Signature of Funerel Sarvice Licenses 22. Nema and Address of Fecility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Betw Onset and Death **Physician** /Medicai tmmedieta Causa (Final week diseasa or condition resulting in death) Examiner The lew requires that the death certificate be executed signed by the attending physician and do be detached for use as the burial-transit Sequentially tist conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Multiple Physician/Medical Part It. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ cate has been sig page 2 should b Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case reterred to medical 28. Place of Deeth (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) P 1 Yes 2 No 3□ DOA After this 28c. Injury at Work? 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of 5 Pending invastigation 1 Netural 1 Yes 2 No deeth. 2 Accident after deeth Director: / in by the 6 Could not be determined 3 ☐ Sulcida 28a. Piece of Injury - At homa, farm, street, tectory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homlcide within 24 hours a To the Funeral D completely filled Hospital 12 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and mannar stated. 29e. Certiflar Medical 29b. Signature end title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Neme and addrass ot person who complated cause of deeth (ttam 23a) (Type, Print) HOWE *EVERUOK* IED E. 31. Dete tiled (Month, Dey, Year) 32. Registrar's Signeture State ulia Davidson JUN 1 9 1998 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Melba Savannah Sease 10, June 1998 6:05 A.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Frederick Health Care Center Frederick Frederick If Under 24 Hrs. Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Deys 1□M 2□F 183-14-8192 Director 76 May 18, 1922 Pennsylvania Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Ves 2 No Completed by Funeral Director Md. Frederick Thurmont 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1 West Moser Rd. 21788 U.S.A. 11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural!" Any Injury or other traumatic events. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: 1 Yes 2 No Specify: Specify: 3∑ Widowed 4 Divorced White 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Manager 11 Apartments 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Claude M. Sherman Mary E. Snyder 19e. Intorment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jack M. Sease (Son) 20 N. Queen St. Shippensburg, Pa. 17257 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete Duniq1 2/2 Cremetion 3 Demovation State Smithsburg Crematory June 11,1998 Smithsburg, Md. 21. Signature of Funeral Service Livens 22. Name end Address of Fecility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) EMPHYSEMA 2 YRS **Examiner** Due to (or es e consequence of) Examiner The law requires that the death certificate be executed the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting In deeth) Lest and Due to (or es a consequença of) Box 68760 attending physician Physician/Medical Due to (or es e consequence of): Division of Vital Records, P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? has certificate 20 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigetion 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, and due to the ceuse(s) end menner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) MO D47611 6-23-98 Nusua 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) I ANEY AVE. FREDERICK MD 21702

MD

Sulia Davidson-Randoll

32. Registrer's Signeture

VJARAVDEKUR

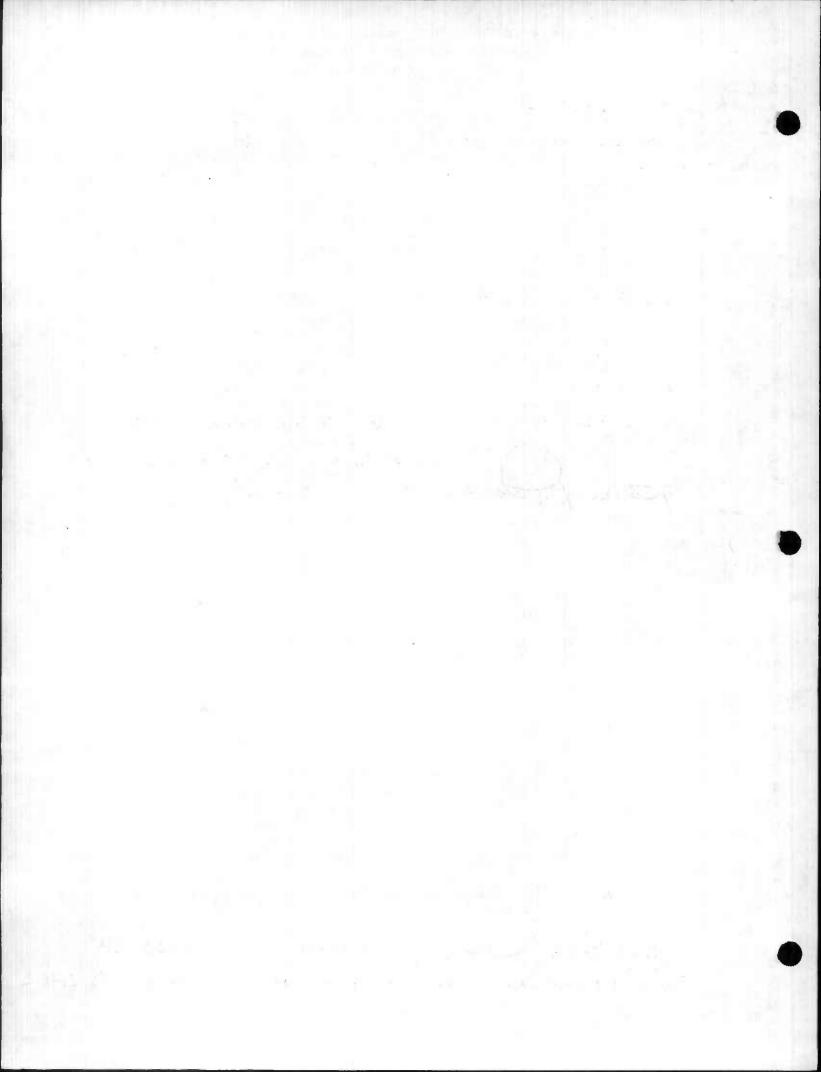
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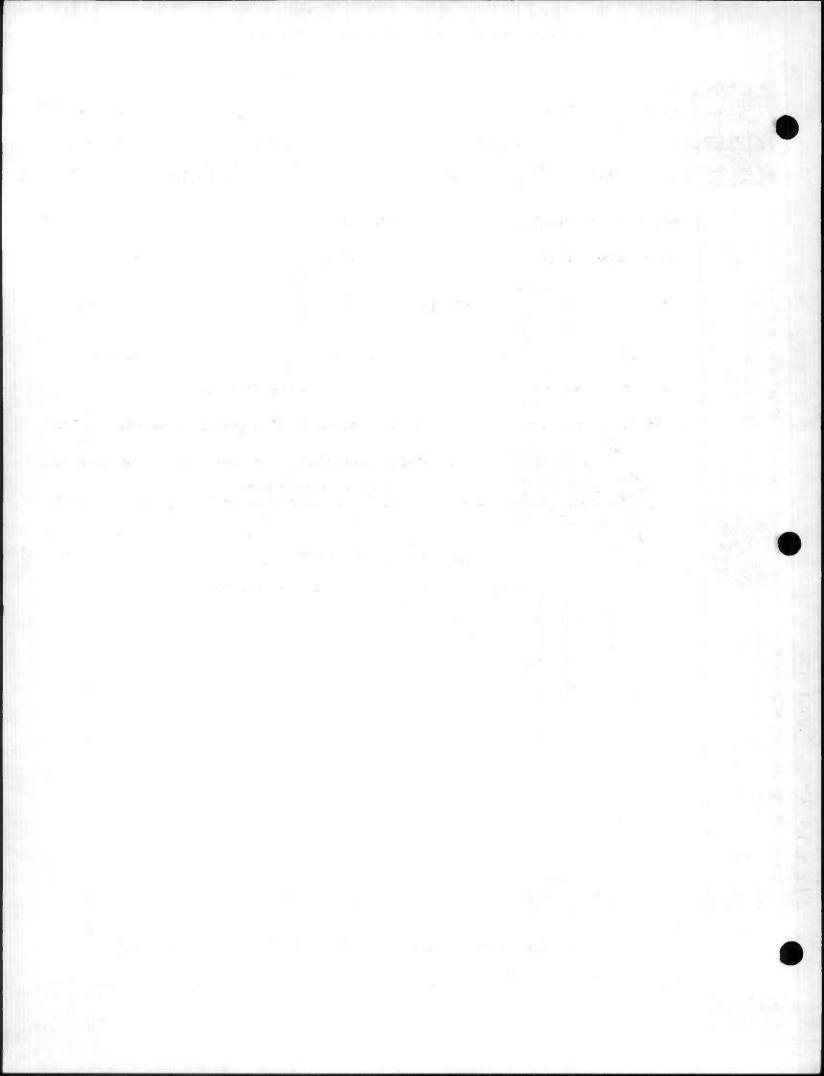
State



State of Maryland / Department of Health and Mental Hygiene

					,	Certifica	ate of	Death	F	Reg. No.	1	401
	Dhualai		1. Decedent's Name (First, Middle, Las	st)					2. Date of Dee	th Day Ye	286	3. Time of Death
	Physici /Medic		Ronald Lee Sande	rs					JUNE	8 19	98	21.00
	Examir		4a. Facility Name (If not institution, give	e street and number)				4b. City, Town, or		4c. County of E	Death	
			Washington Count	y Hospita				Hagers			hing	ton
	Funeral		Sociel Security Number 6. S	ex 7. Ag	e (In yrs. lest birt	Month	der 1 Yeer s Days			y, Year) 9.	Birthpled	ce (State or Foreign
	Director		234-60-3415	ASIM ZUF	60	rs.		Dec.30	,1937		Virginia	
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					100	I. Inside City Limits
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	the Maryla 28a-f eho nomed at	ect	10e. Street end Number	gron	П		Zip Code			10g. Citizen of Wha	t Countr	
	₩ 6 €	Funeral Director	11600 Peacock Tra									,,,
	rs 23a	era	11. Maritel Status	12. Wes Decedent	Ever in U.S.		21742		necify Yes or No-	USA 14. Race -		Indian
	fler dea	F	1 Never Married 2 Married	Armed Forces?		If Yes, s	pecify Cul	Hispanic Origin? (S ban, Mexicen, Puer	to Rican, etc.)	Black, V	White, etc	
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/la	should be of Mental marked o	To	Gilbert F. Sand	ers				Alice	Pearl Bea	ale		
Maryland	bud B E E	.	19a. Informent's Name/Reletionship (Type, Print)	19b.	Malling Addre	ess (Stree	ot end Number or R	ural Route Numbe	r, City or Town, Ste	ite, Zip C	ode)
	of Health item 27 I		David G. Sanders/	Son					Hagersto	wn, Maryl	and	21742
ore	it of He if item or oth		20a. Method of Disposition 1 Burlal 2 Cremation 3 D	Removel from State	20b. Place of cemeter	Disposition (A y, cremetory o	leme of or other ple	ece)	Dete	20c. Location - City	y or Towr	n, State
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Baltimore,	permit. Pagas Department of Important: If it any Injury or once.		21. Signature of Edineral Service Licen	00		22. Name	end Addr	ess of Facility	omo			·
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			23a. Part 1. En or the disease, or companies shock, of leart failure. List only	olications that caused	the death. Do n	ot enter the m	ode of dy	ing, such es cerdia	c or respiratory an	rest,	A	pproximate
	Physician		SHOOK, Cornealt lanure. List only	one cause on each iii	10.				A			ntervel Between Onset end Death
	/Medicai		Immediate Cause (Final disease or condition		1010	La	Pne	nary /	Direct		1/	3 minut
	Examiner		resulting in death)	а.	Due to (or as a c	onsequença o	of):	10	^			
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ó,	e axe ian a urial-	Ö	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events								1	
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	e de the e	sic	Part II. Other significant conditions co	entributing to death b	ut not resulting In	the underlying	g cause g	iven in Part i.	23b. Did t	obacco use contri	bute to ti	be cause of desth?
P.0	that the de led by the e detached f								101	res 2□No 3j	Probal	bly 4 Unknown
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Records,	v requires been sign should be	Completed							24a. Was a		sysile	autopsy findings able prior to detion of cause
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Sio	eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1[]Yes 2 □ No				
Division	ftar d	Certification:	4 Homicide determined	28e. Plece of Injuding, etc.	ury - At home, far c. (Specify)	m, street, fact	ory, office)	28f. Location (S City or Tow	itreet and Number o n, Stete)	or Rural F	Route Number,
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	To the Hospital or Attending Phywithin 2 Hours after death, within 2 Hours after this completely filled in by the funeral completely filled in by the funeral	edicai	29e. Certifier 1 Certifying Phy (Check only one) 2 Medicai Exam	rsician: To the best of Iner: On the basis of	examination and	deeth occurre Vor Investiget	ed et the ton, in my	ime, date and place opinion, death occu	e, and due to the curred at the time, o	ause(s) and manne late and piece, and	or as stet	ed. ne cause(s)
	thin the	ĕ	29b. Signature and title of certifier	and manner sta	Ned.	- 13	9c Licen	se number	- 13	29d. Date signed (N	donth. Dr	v Year)
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			30. Name and address of person who o	completed dause of d	eeth (Item 23a) (Type, Print)	170	(n) -0	ANCISCO	1.01	nnu	ANE
			31. Date filed (Month, Day, Yeer)	32 Bloth	I's Spection	TIV -	~/ / 4	U PK	P1/0476	V1 19X	VI	-BV(
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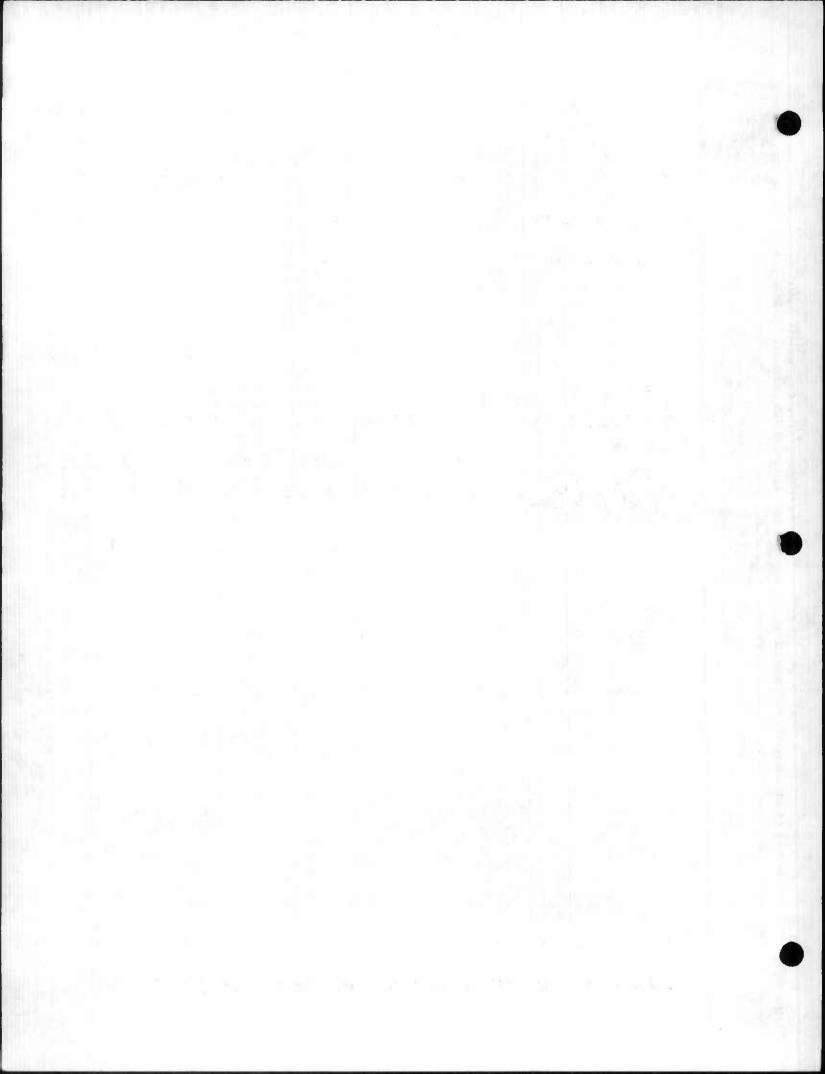
Ronald her Sanders



				tate of Ivial	•	Certifica:		Death	-	Reg. No.	2.1	452		
П	Physici	an	1. Decedent's Name (First, Middle, Last) Aaron Glen STEINER						2. Date of De Month	Day	Year	3. Time of Death		
	/Medic								June 4	1		4" PM		
E I	Examir	ner	4a. Fecility Neme (If not institution, give street 1911 Dual Highway	et end number)			(4b. City, Town, or L Hagerst		,	of Death hingt	on		
-	Funeval	7	5. Social Security Number 6. Sex	7. Age (i	In yrs. iast birth	day) If Unde	r 1 Yeer	If Under 24 Hrs.	8. Date of Bir	rth	0			
	Funeral Director		218-09-6782 Usual Residence of Decedent		-	rs. Months	Deys	Hours Min.	(Month, De	sy, Year) 5, 1919	Wes	lace (State or Foreign try) st Virginia		
	anyland show d at	-	10a. State 10b. County		Oc. City, Town						10	0d. Inside City Limits 1 ☐ Yes 2X No		
	Ne Me	Director	Maryland Washingto	n		1		town						
	th with the		10e. Street and Number 1911 Dual Highway			10f. Zi	Code 21	740		10g. Citizen of What Country? USA				
020	7.72 hours after death with the Maryland "natural", or items 23e or 28e-f show solcal Examinet must be notified at	by Funeral	1 Never Merried 2 Married	Wes Decedent Eve Armed Forces? I X Yes 2 ☐ No t Yes, Give Year or Dates:	er In U,S.	13. Wes Dece If Yes, spe 1 \(\text{Yes} \)		lispenic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specify	e - Americ ck, White, o			
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<u>ya</u>	2 should be to and Mental It is marked of raumatic even	To	Russell G. Steiner					Dora Bu						
Mar	d 2 should th and Men 7 is marks traumatic		19e. intorment's Name/Relationship (Type, I Julia Ruth Steiner -			- 100		and Number or Rui						
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altlmore,	permit. Pages 1 a Department of Hei important: if item any injury or othe once.		1 ☑ Buriei 2 ☐ Cremation 3 ☐ Remo	val from State		crematory or Creek			-8-98			k, Maryland		
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Ö	89 E 8 9		1. Signeture of Funerei Service Licansee 22. Neme end Address of Fecility MINNICH FUNERAL HOME 415 E. Wilson Boulevard, Hagerstown, Md. 21740											
			23a. Part 1. Enter the disease, or complication shock, or heart tailure. List only one car	ons thet caused the	e deeth. Do no	ot enter the mo	de of dylr	ng, such es cardiac	or respiratory e	errest,	j t	Approximete intervai Between		
	Physician /Medical Examiner		immedlete Cause (Finel disease or condition	L	une (0000						Onset and Deeth		
B	Examiner	resulting in deeth) Due to (or as a consequence of):												
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of Vital Records,	been should	Completed b							24a, Wes	en eutopsy ormed?	ava	ere autopsy tindings aliable prior to mpletion of ceuse death?		
Ä	0 - 6	mo/							10	Yes 2 No	10	Yes 2□ No		
/ita	ician: The certificate rector, par	Be	25. Wes cese reterred to medical exeminer?					26. Place of Dea	th (Check only	one)				
n of \	Physical di	on: To	1 Yes 2 No Hosp	itai: 1 ☐ inpatient 8a. Date of Injury (Month, Day Y	28b. Ti	ne of jury	OA Oth 28c. injur Wor	4 Li Nuising H		ldence 6 □Oth how Injury occur		γ)		
sio	the the	catl	2 Accident investigation			М		Yes 2 □ No				10		
Division	si or Attendest s after deat if Director: ed in by the	Certification:	4 Homicide determined 2	8e. Piace of Injury building, etc. (- At home, farr Specify)	n, street, facto	y, office			(Street and Numb wn, State)	er or Hura	il Houte Number,		
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:		aminetion and									
	s de de de de de de de de de de de de de							e number		29d. Dete signe	d (Month,	Day, Year)		
			I michael ?	Melon	sel 1	no	0	41667		6.5	.98			
			30. Name and address of person who complete Michael J. McCo							~ /3. in	*	bus 102124		
	Cto	10	31. Date tiled (Month, Day, Year)	32. Registrar's	//// O	IVE A.	ed (ampos 12	P1. 3 40 7	1,00 11	Le Jens	,-00/1 /100 11/1		
	Sta Registr		31. Date tiled (Month, Pay Year) 8 199	& July	ia Davidso	n-Randas	2							

1 20 T C

Physician	Decedent's Name (First, Middle,	Last)		00	lilicati	e or i	Death	2. Dete of	Reg. No.	V. L.	3. Time of Death	
	ANNIE AMELI	IA SUMMER	{					June	Dey 4	Year 1998	- AN 1100	
/Medical Examiner	4a. Fecility Nama (If not institution,					4	b. City, Town, or			nty of Death	6:45PM	
	REEDERS MEMOR	RIAL HOME					BOONSE	ORO	V	WASHINGTON		
Funeral				last birthday)	If Under Months	1 Year Days	If Under 24 Hr	8. Dete of I			place (State or Foreign	
irector	218-40-3931	1□ M 2X F	95	Yrs.	Indiano	Dayo	Tiours Mill	8. Dete of (Month, NOV.	21, 190	2 N	IARYLAND	
ž ==	Usuel Residence of Dacedent 10e. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
28a-f show notified at rector	MARYLAND WASHI	NGTON				ROON	NSBORO				1⊠Yes 2□No	
be routed at	10e. Street and Number	1101011			10f. Zip		DDORO		10g. Citizen	of What Cou	ntry?	
	141 SOUTH MAIN	STREET				-	21713			U.S.A.		
Funerai	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U,	S. 13.	Was Deced		ispanic Origin? (In, Mexican, Pue	Specify Yes or I	No- 14. F	Race - Americ Bleck, White,	can Indian,	
	1 Never Married 2 Marrie	d 1 ☐ Yes 2 🛭 If Yes, Give	No		1 ☐ Yes 2		Specify:	10 1 110 211, 0101,		-14		
d by	3 Widowed 4 Divorced	Year or Dates	: 1								WHITE	
Slete	15. Decedant's (Specify only highest	grede completed)		(Give	dant's Usua kind of wor DO NOT us	k done d	during most of wa	rking	16b. Kind o	f Businass/In	dustry	
Completed	Elemantary/Secondary (0-12)	Collaga (1-4o	7 5+)			RSE	,		MTSSTO	NARY	TO AFRICA	
BeC	17. Fether's Nama (First, Middle, La	ast)					18. Mothar's Na	me (First, Midd				
	THOMAS H. SUMMER GENEVA								UNG			
To	19a. Informant's Name/Raiationship						end Number or R					
	JUNE HARRIS/NIE 20a. Method of Disposition	ECE	anh Di	20747 ace of Dispo			LL ROAD,		1			
	1 Burial 2 □ Cremation 3	Removal from State	9 06	emetery, crer	netory or ot	her plac	1	Deta	20c. Locatio	on - City or To	own, State	
	4 Donation 5 Other (Specify) ST. MATTHEW'S CEMETERY 6/9/98 HAGERSTOWN, MARYLA											
any injury or or	Paul M. Dean BAST FINERAL HOME 7606 Old National Pike											
	23a. Part 1. Enter the diseese, or co	lan						Boonsb	oro, Ma	ryland		
ician dical niner	shock, or heert fallure. List or Immediate Causa (Final disease or condition rasulting in death)		een	we	Pa	em					Approximete Interval Between Onset end Death	
ē l				as e consec			0					
dical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disaase or Injury											
Medical	Ceuse (Disaase or Injury thet initiated events resulting in death) Lest	C	Due to (or	as a conseq	uenca of):							
deteched for use es		d										
ysic	Part ii. Other significant conditions					use give	en in Pert I.	23b. DI	d tobacco use	contribute to	the cause of death?	
by Ph	Anterionclaw	the cand	insu	inden	Dir	un	~	1[Yes 2 N	o 3 Pro	bably 4 thinow	
pd by	Artico reland							24e. We	s an autopsy	24b. W	ere autopsy findings ailabla prior to	
6								pe	formed?	CO	ailabla prior to mpletion of cause death?	
								10	Yes 2 □ N o		Yes 2□ No	
omp							26. Piace of De				2010	
Comp	25. Was cese rafarrad to medical								one)			
Comp	25. Was cese rafarrad to medical examinar? 1 \(\text{Yes} \) 2 \(\text{PNO} \)	Hospital: 1 ☐ Inpat	iant 2 🗆 E	R/Outpatien	t 3 DO	Othe	NP:		sidence 6 🗆	Other (Specify	y)	
To Be	examinar? 1 Yes 2 HVo 27. Manner of Death 1 GNatural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, Di	urv	ER/Outpatien 28b. Tima of Injury		c. Injury Work	or: 4 19 Nursing I	lome 5 Re	-		γ)	
on: To Be Comp	examinar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Date)	ury ey Year)	28b. Tima of injury	M 26	C. Injury Work	4 14 Nursing I	lome 5 ☐ Re 28d. Dascrib 28f. Location	sidence 6 🗆 0 e how injury occ	curred	y) il Routa Number,	
uneral director, page 2 on: To Be Comp	examinar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Sulcide 6 Could not determine 29a. Certifier 1 Cartifying 8	28a. Date of Inj (Month, Date	ury ay Year) ijury - At hor tc. (Specify) of my know	28b. Tima of injury me, farm, stre	M 28	c. Injury Work 1 1	e date and place	28d. Dascrib 28f. Location City or T	sidence 6 0 e how injury occ (Street end Nu own, State)	mber or Rura	il Routa Number,	
on: To Be	examinar? 1 Yes 2 No 27. Manner of Death 1 Yes accident 5 Pending investigat 3 Sulcide 6 Could not determine 29a. Certifier (Check only one) 29b. Signeture and title of certifier	28a. Date of Inj (Month, D) 28e. Place of In building, a 28e. Place of In building, a Phyalcien: To the basis aminar: On the basis of and menner's	ury ay Year) ijury - At hor tc. (Specify) of my know	28b. Tima of injury me, farm, stre	M 28 M eet, factory, occurrad a estigation,	office t tha tim in my op	e date and place	28d. Dascrib 28f. Location City or T	sidence 6 0 a how injury occ (Street and Nu own, State) e cause(s) and a, date and place 29d. Date sig	mber or Rura manner as si e, end due to	al Routa Number, latad. the cause(s) Day, Yeer)	
uneral director, pege 2 on: To Be Comp	examinar? 1 Yes 2 No 27. Manner of Death 1 Yes accident 5 Pending investigat 3 Sulcide 6 Could not determine 29a. Certifier (Check only one) 29b. Signeture and title of certifier	28a. Date of Inj (Month, D) 28e. Place of Ir building, a 28e. Place of Ir building, a	ury ay Year) ijury - At hor tc. (Specify) of my know	28b. Tima of injury me, farm, stre	M 28 M occurred a estigation, 29c.	office t tha tim in my op	e, date end place	28d. Dascrib 28f. Location City or T	sidence 6 0 a how injury occ (Street and Nu own, State) e cause(s) and a, date and place 29d. Date sig	mber or Rura manner as si e, end due to	al Routa Number, latad. the cause(s) Day, Yeer)	
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Physici /Medic

Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Machinal Examinet must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink.	Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene 2 1 4 5 is

			Certif	icate of l	Death		Re	g. No.	100	1909
	Decedant'a Nama (First, Middle, Last)		,			2.	Dete of Death Month	Dey	Year	3. Time of Death
an al	Milton	Idrumldon S	HTIM		b. City, Town,	3	116-	3	98	1630
er	4a. Facility Neme (If not institution, give st	reet end number)		4	b. City, Town,	or Locat	ion of Death	4c. Count	y of Death	,
	Washington County	Hospital			Hagers	stown	n	V	Vashi	ngton
	219-14-0740	7. Age (In yrs. I		Under 1 Year onths Deys	If Under 24 Hours	Vlin.	Dete of Birth (Month, Day, une 6,	Year) 1925	Cour	place (State or Foreign otry) y Land
	Usual Rasidance of Decedent 10a. State 10b. County		, Town or Location						1	0d. Inside City Limits
cto	Maryland Washing	ton	над	erstown						1 Nes 2 No
al Dire	10e. Street and Number 117 W. Howard Street	et	1	Of. Zip Code	21740		10g. Citizen of What Co USA			itry?
by Funeral Director	11. Marital Status 12 Married 3 Widowed 4 Divorced	2. Was Decedent Ever In U, Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: W • W	10	Decedent of His, specify Cuba		? (Specifi uerto Ric	y Yes or No- en, etc.)		ce - Americack, White,	
Be Completed by	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Decedent	's Usual Occupa of work done of NOT use retired	ation luning most of	working	1	6b. Kind of E	Business/Inc	dustry
шс	Elamantary/Secondary (0-12)	Collaga (1-4or 5+)		ruder o				plast	ic mf	g.
Ö	17. Father's Name (First, Middle, Last)	Ů,			-		irst, Middle, M	•		
B	Charles Smith						e Dori			
2	19a. Informant's Name/Relationship (Type	e Print)	10h Mailing A	ddraen (Ctmat	and Alumbasa	e Dural D	lauta Alumbas	City of Tour	Ctata Tim	Code
	Bettyjane Smith -	wife	112 W.	Howard						
	20a. Mathod of Disposition 1 🖾 Burial 2 Cremetion 3 Rei 4 Donation 5 Other (Specify)	moval from State	lace of Disposition emetery, cremato se Hill	ry or other plac	•	6-5-		Oc. Location		own, State Maryland
	21. Signeture of Funeral Service Licensee			ame and Addres			NICH F			
	1 -104	w		5 E. Wi	•					
_	23a Part T. Enter the disease, or complication	1/unn	-						, IId.	Approximate
	Immediate Causa (Final disease or condition resulting In death)	Corge Dua to (or	Struz ras a consequan	(de 2007):	TFA	ر ا س	re			Interval Between Onset and Deeth
Aedicai Examiner	Sequentially list conditions		as a consequen	3	Ber	ech	ζ			your
al Ex	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Causa (Disaase or Injury that Initiated events									
Medic	resulting in death) Last	Due to (or	as a consequent	ce of):						
clan]	
y Physi	Part II. Other significant conditions contri	ibuting to death but not resu	ilting in the under	riylng ceusa give	en in Part I.		23b. Did tol		3 ☐ Pro	the cause of death?
Be Completed by Physician/							24a. Was an perform		av.	are autopsy findings allable prior to mpletion of ceuse daath?
ပ္ပ							1 ☐ Ye	s 2ETNo	10	☐ Yes 2☐ No
Be	25. Was casa raferred to medical examinar?					Death (C	heck only one)		
٥	1 ☐ Yes 2 ☐ No Ho		ER/Outpatient 3	DOA Othe	er: 4 🗆 Nursir	ng Home	5 Reside	nce 6 🗆 Ott	her (Specif	y)
tion:	27. Mannar of Death 1 Natural 5 Pending 2 Accident Invastigation	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injun Work	rat k? Yes 2 □ No	280	I. Describe ho	w Injury occu	rred	
Medical Certification:	3 Suicide 6 Could not be datarmined	28e. Placa of Injury - At ho building, etc. (Specify	me, farm, street,	fectory, offica		281.	Location (Str. City or Town,	eat and Num State)	ber or Rura	t Route Number,
edical	29a. Certifier (Check only one) 1 ☐ Certifying Physic 2 ☐ Medical Examine	cian: To tha bast of my know r: On tha basis of examinati and mannar stated.	vladge, death occion and/or Invasti	curred at the tim gation, in my or	a, data and p pinlon, death o	laca, and	due to tha ca at the tima, da	use(s) and m ta and place,	annar as s and due to	ated. tha causa(s)
Σ	29b. Signature end title of certifier	a Over her.	>	29c. License	number 578	-2-	29	d. Date signi	3 - 5 4	
	30. Nama and address of person who com Dr Hornbaker 11	plated cause of death (Item	23a) (Type, Print	1003	Rd.	K	6955	40111	M.	ryland
e	31. Date filed (Month, Day, Year) JUN 0 8 1998	32. Registrar's Signat	dres Prod	000			1	WW II	- 100	7 100.150
	A	0.00000	40301 4-1 1001 100	-,UG						

Sta Registra

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BALTIMORE, MARYLAND 21215-0020

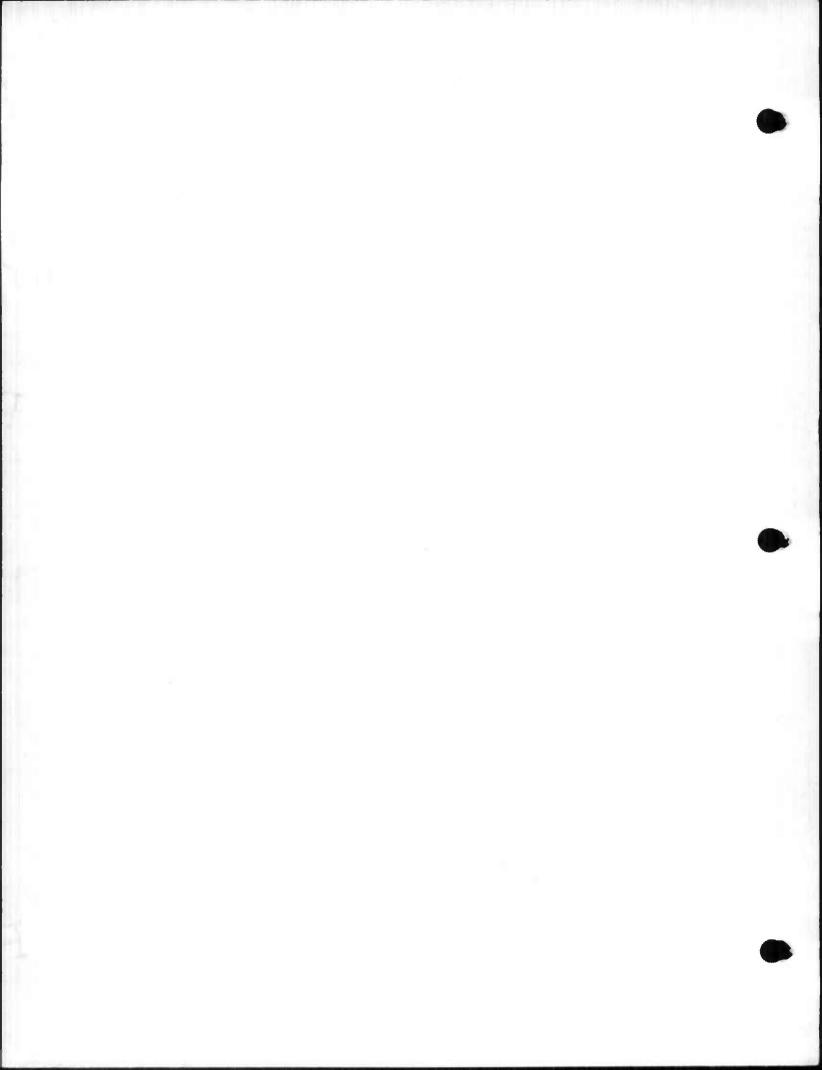
DIVISION OF VITAL RECORDS, P.O. BOX 68760

6 may be retained by the hospital or attending physician.	ctor, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	nust be notified at once.	
PITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the bospital or attending physician.	HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE N	TO THE F be filed w	IMPORT	

							98	21455
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMI ERTIFICA			MENTAL HYGIEN	E	
TOR	4. SOCIAL SECURITY NUMBER 5	rederick s. sex o. AGE (in yrs. lost DM 2 pr 54	SWW #U t birthday) # U YRS. MONT	NDER I YEAR	FUNDER 24 HRS. HOUTIS MEN. OR LOCATION OF DE	2. DATE OF DEATH MONTH DATE OF DEATH (Month, Owner, (Month, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner, Owner	99 8. Bif	THPLACE (State or Foreign untry) nicago, IL
AAL DIRECTOR	10a. STATE 10b. COUNTY IL 10a. STREET AND NUMBER	Will	10c. CITY, TO	Boli	ngbrook . zip code		10g. CITIZEN O	16d. INSIDE CITY LIMITS? 1 X YES 2 NO F WHAT COUNTRY?
BY FUNERAL	228 Pamela Drive 11. MARITAL STATUS 1	2. Was decedent ever in U.S. Ari Forces? 1 1 Yes 2 12 N IF Yes, give war or dates	MED O	If yes, sp	ENDENT OF HISPAN)44() IIC ORIGIN? (Specity Yea n, Puerto Rican, etc.)	Bi	SA ACE — American Indian, lack, White, atc. Decily: White
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last)		CEDENT'S USUA ve kind of work d Do NOT use retir	one during mo ad.)	st of working		gh Schoo	
TO BE CO	Eugene F Swanson 190. INFORMANT'S NAME (Type/Print) Sylvia Swanson/Wif				Ethel Ind Number or Rural F	ME (First, Middle, Maiden	Rob	
	20a. METHOD OF DISPOSITION 1 N Burlel 2 Cremation 3 Remova 4 Donellon 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN	al from State 20b. PLACEA cametery, cref	ND DATE OF DIS natory or other pl .Crest	POSITION (Na ace) Cemete 22. NAME AI Stewa	ma of Ery NO ADDRESS OF FAC IT Funer	7/3/98 E	cation — chy or Bolingbr	Town, State
	IMMEDIATE CAUSE /Final	polications that caused the der it only one cause on each line. ANTEND SCE DUE TO (OR AS A CONSEO	EROT	ntar the mo	de of dying, auci	0	ratory arreat,	Approximata Interval Batween
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEO						
MEDICAL C	PART II. Other algnificant conditions of	contributing to death but not re	esulting in the	underlying	g causa given in	Part I. 24s. WAS AN PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN:	DID TOBACCO USE CONTRIB		OF OEATH (Ch	eck only one)	UNCERTAIN			
ETED BY PHY	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined	28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY — At hon building, etc. (Specify)	26b. TIME OF INJURY	28d. OESCRIBE HOW IN 28d. LOCATION (Street e City or Town, State)		al Route Number,		
O BE COMPLE		N: To the best of my knowledge, deal on the beels of examination and/or in				lime, date and place, and		

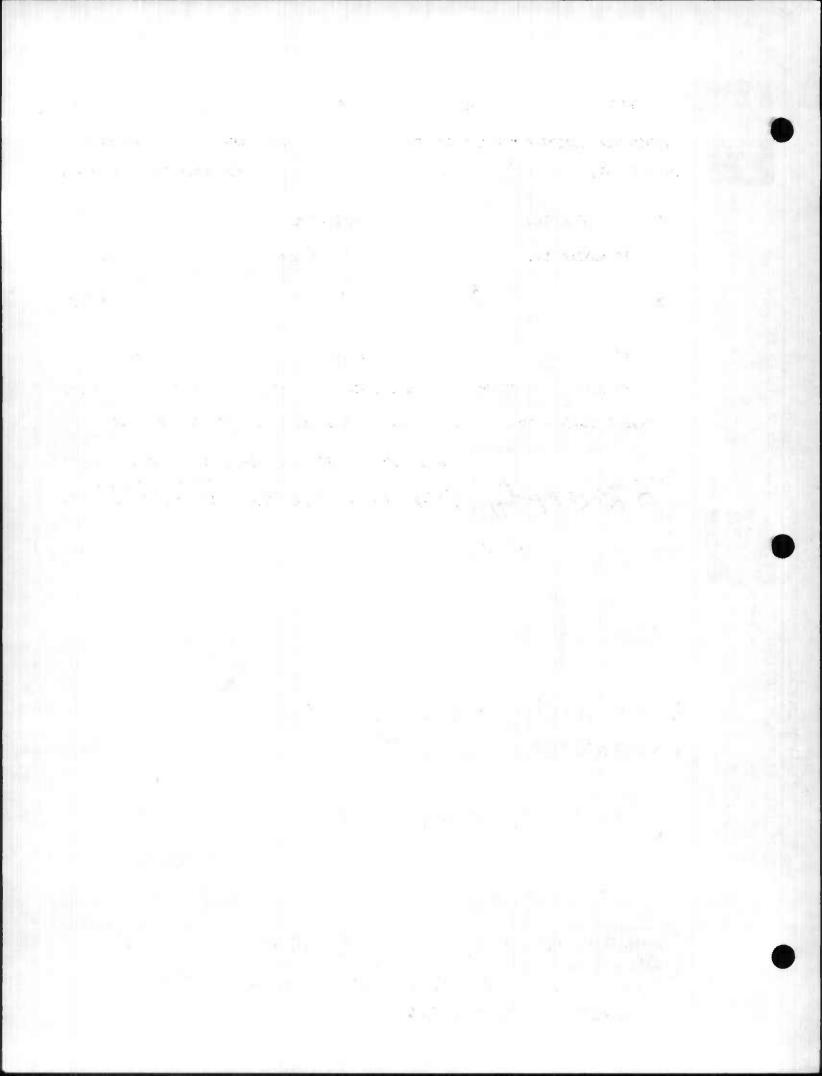
30. NAME AND ADDRESS OF FOR 31. DATE FILED (Month, Day, 1967) JUN 3 0 1 Dr. P. Danie Miller, DO 22. REGISTRAR'S SIGNATURE

1998



State of Maryland / Department of Health and Mental Hygiene

					Oldio or im	ar y larra		ertificate			Mondarry	Reg. No.	21	456	
			1. Decedent'a Neme (F	irst, Middle, Las	st)						2. Dete of De Month		Year	3. Time of Death	1
п	Physicia /Medica		BETTY	7.	JEA	N		SCO	TTO		June	- 26,1	PPP	2045	1
	Examine		4e Facility Neme (If no	t institution, give	street end number)					4b. City, Town, o	r Location of Deat	h 4c. County	of Deeth		
			PENINSULA	REGION	AL MEDICA	L CENT	ER				ISBURY		ICOM]	CO	
	Funeral Director		5. Sociel Security Number 220-28-167 Usuel Residence of Da	0 1	ex 7. Ag □M 2 X F	a (In yrs. lest	birthda Yrs.	y) If Under Months	1 Year Deys	If Under 24 H Hours Mi	n. (Month, Di	o of Birth oth, Day, Year) 9. Birthplece (Sta Country) MARYLAN			ign
	wo m			b. County		10c. City, T	own or	Location					11	Od. Inside City Lim	its
	Many many many many many many many many m	io	MD	WICOMI	CO			SAI	LISE	URY				1 X Yes 2 □ I	VO
	or 28	Director	10e. Street and Numbe	er				10f. Zip	Code			10g. Citizen of V	Whet Coun	lry?	
	23s	100		NAYLOR S		Free in II C	140	Was Dasad	lant of t	21804	(Sanaih: Van ar N		S · A		
020	w 0 5	by Funeral	11. Marital Status 1 Naver Merried 3 X Widowed 4		12. Was Decedant Armed Forces? 1 Yes 2 X If Yes, Give Year or Datas:		16	If Yes, spec		Specify:	(Specify Yas or No arto Rican, atc.)	Specify	ck, White,		
2-0	in 72 hours		15 (Specific	. Decedent's Ed	lucation	16a. Decedent's Usuel Occupation (Giva kind of work done during most of a					vorking	16b. Kind of Bu	usiness/Ind	lustry	
21215-0020		Completed	Elementery/Seconda		Collega (1-4or 5	i+)	life	. DO NOT us	retire	d)	rorking	NUR	SING		
pu	年工名を	Be	17. Fether's Neme (Firs	st, Middle, Last)						18. Mother's N	ama (First, Middle	, Meiden Sumen	na)		
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			JANET L.	WASSO	1	E. C.	PRR	n dr		DALUS	BURY	(1)			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JÜLY JOHN DAUGHERTY STEWART 1998 5:40PM 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11280 KEOKEE COURT ISSUE CHARLES COUNTY If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month) Day, Year) OCT • 16, 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 11XM 2□ F Months Yrs. INDIANA, PA 579-18-2274 82 Usual Residence of Decedent 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND CHARLES ISSUE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11280 KEOKEE COURT 20645 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRESIDENT(RET.) BUREAU NAT. AFFAIRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ERNEST T. STEWART CAROLINE DAUGHERTY 19a. informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGRET STEWART-SPOUSE SAME AS #10 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cametery, crematory or other place)
4 Donation 5 Other (Specify) METROPOLITAN CREMATORY 7-2-98 ALEXANDRIA, VA. 21. Signeture of Fuperai Service Licansee 22. Name and Address of Fecility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 207646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a ESOPHAGEAL CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day Year) 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of cartified 29c. License number 29d. Date signed (Month, Day, Year)

bunial-transit requires that the death certificate be executed and Box 68760, attending physician the 98 P.O. yd bengis Records, 20 Deen certificate hes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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r than "natural", or items 23a or 28s-f show the Modical Examiner must be notified at

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permit, Pages 1 and 2 should be filled with Department of Heelth and Mental Hygian Important: If Item 27 is marked other that any Injury or other trauments.

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Examiner

Examiner

Physician/Medical

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Completed

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10

Medical Certification:

Baltimore, Maryland 21215-0020

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HENRY BURKE, M.D., 31. Date filed (Month, Day, Year)

JUL 0 2 1998

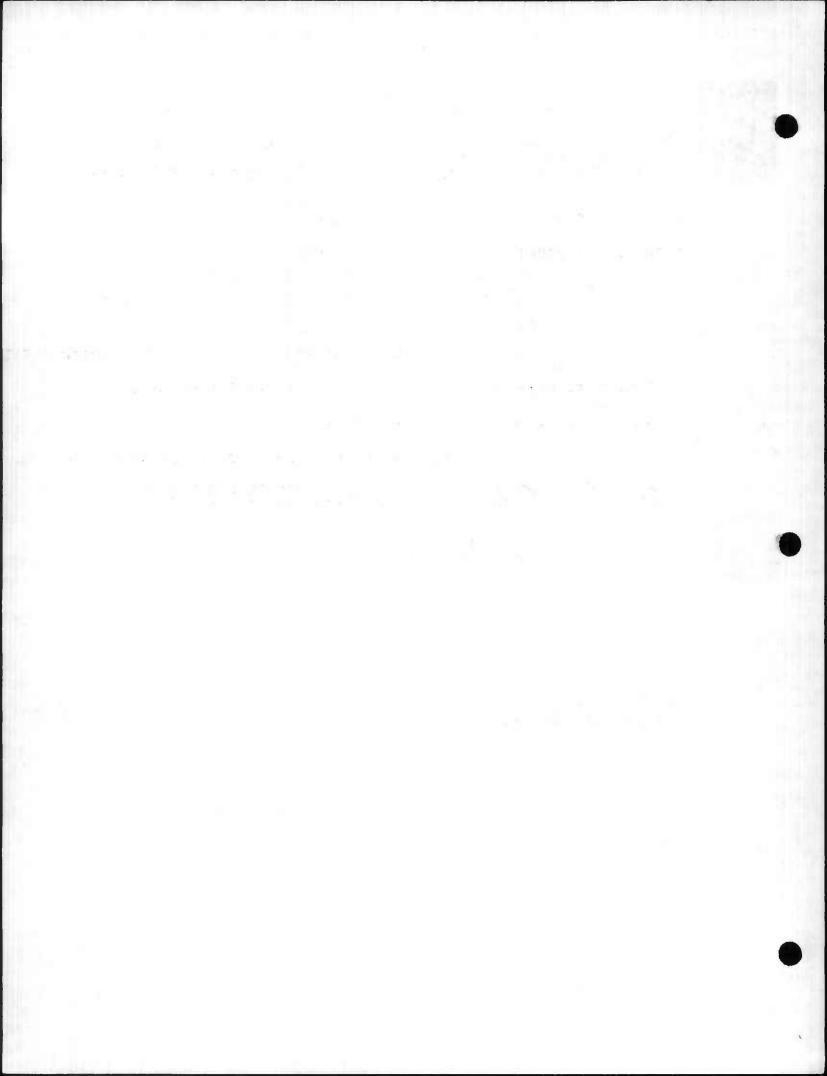
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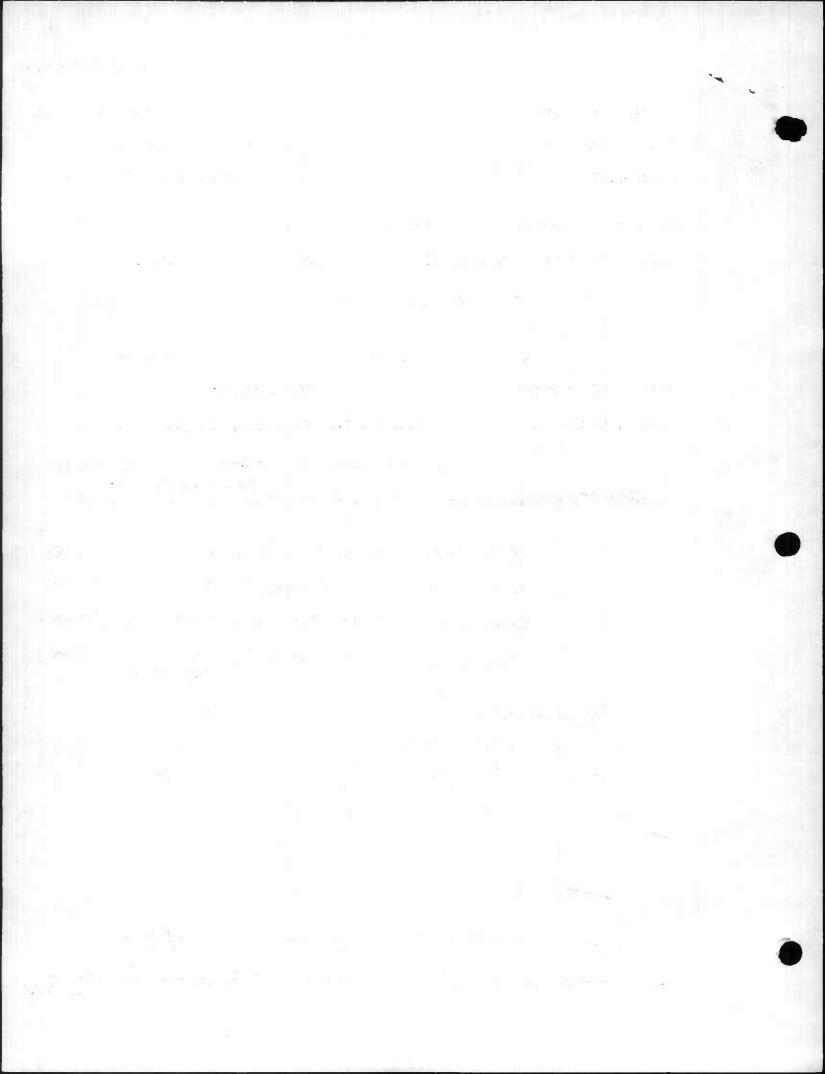
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32. Registrar's Signature

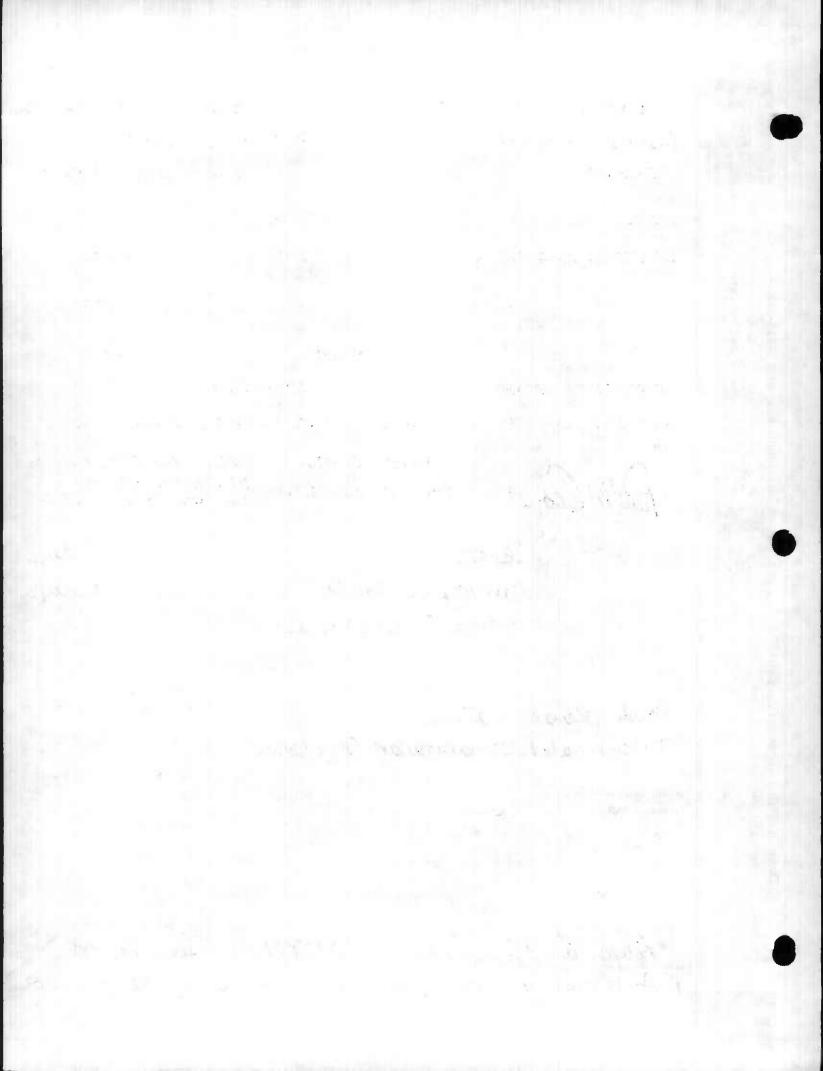


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23e. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardinated shock, or heart failure. List only one ceuse on each line.	rd. Hagerstown, Md. 21740 ac or raspiratory arrest, Approximata Interval Between
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signatura and little of certifier 29b. Signatura and little of certifier 29c. Licansa number	ce, and due to the cause(s) end manner as stated. curred at the time, date and place, end due to the cause(s)
1 10 gm 10 . 24.5031	29d. Daje signed (Month, Day, Year) 6/16/98.
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) DR 5+1A+1AB Z SIDDIQUT 19414-CLGT State 31. Date filed (Month, Pay Year) 9 1998 32. Registrar's Signature State Substitute Author - Randoll	



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Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month June **Physician** ELLA MILDRED TROZZO 04:15 /Medicai 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 7. Age (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 904 5. Social Sacurity Number 9. Birthplace (Stete or Foraign **Funeral** 1 M 2 TYF Pennsylvania 178-32-4134 Director Usual Residence of Decedent the Marylan 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show a notified at 1 Yas 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 7 is marked other than "natural", or items 23a or : traumatic event, the Medical Examinar must be n 1915 Maplewood Circle 21740 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) Race - American Indian, Black, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Merital Hygiene. Important: If item 27 is marked other than "natural" or leastly injury or other traumatic. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify ď 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highast grade complated) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Joseph Kaiser Barbara Daskev 0 19e. tnforment's Neme/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Phyllis Rouse, Daughter 1915 Maplewood Circle, Hagerstown, Maryland 21740 20e. Method of Disposition 20b. Placa of Disposition (Neme of 20c. Location - City or Town, State WESTINOTE I AND "COUNTY 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park June 12 Greensburg, Pennsylvania 21. Signature of Funeral Service Licenses ²² Name and Address of Facility
Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) aspiration pneumonia 48 hours Examiner Due to (or as a consequenca of): Examiner dyaphagia years sician end burlei-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): physician s the burie years end-stage organic brain syndrome Physician/Medical that initiated events rasulting in death) Last Due to (or as a consequence of): 80 980 ò Part tt. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yes 2 No 3 Probably 4 Unknown Renal failure þ 8 24b. Were autopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy performed? Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No funeral 28a. Dete of Injury (Month, Dey Year) 27. Mapner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending deeth. 1 Yes 2 No investigation 2 Accidant Hospital or Attending 24 hours efter deeth
 Funeral Director: A 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Place of Injury - At homa, ferm, straet, factory, offica building, etc. (Specify) 4 - Homicide 29a. Certifiar 🖄 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated. edical 2 Madicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) To the To the F 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number D32518 June 10, 1998 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Dr. Guedenet, 100 Geeting Lane, Keedysville, Maryland

32. Registrer's Signeture

Lukia Miridson Randale

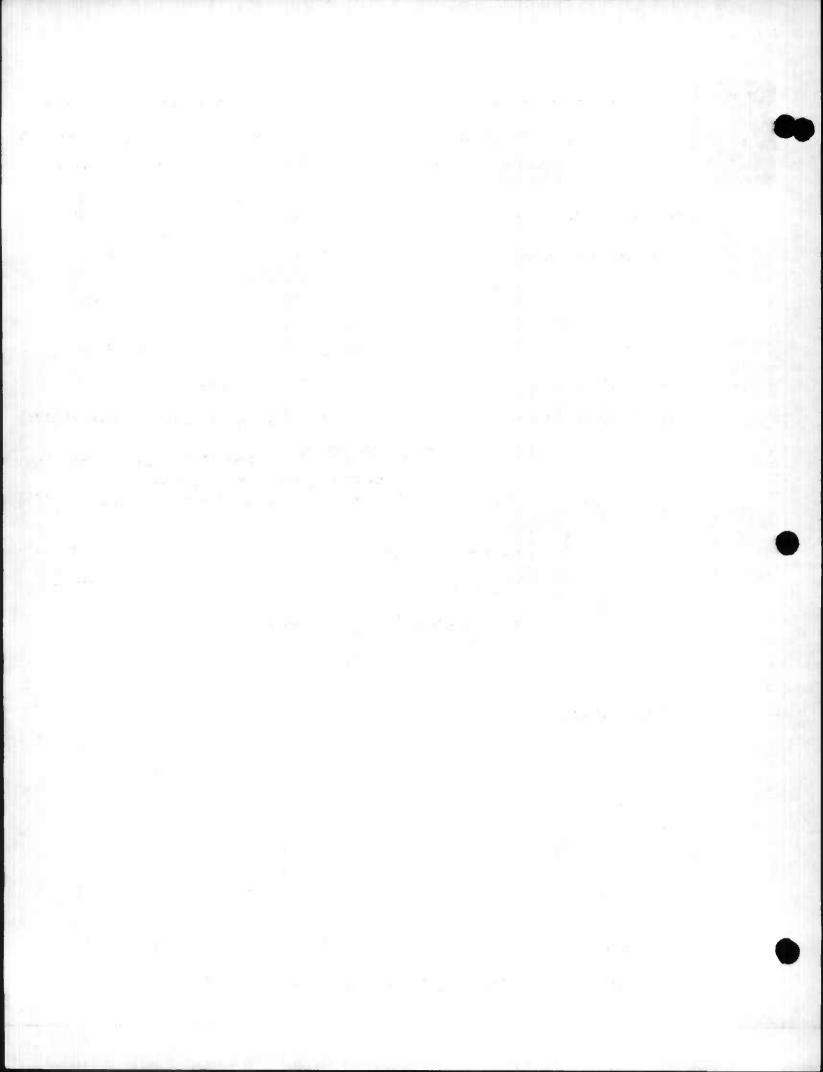
State Registrar

Baltimore, Maryland 21215-0020

Box 68760

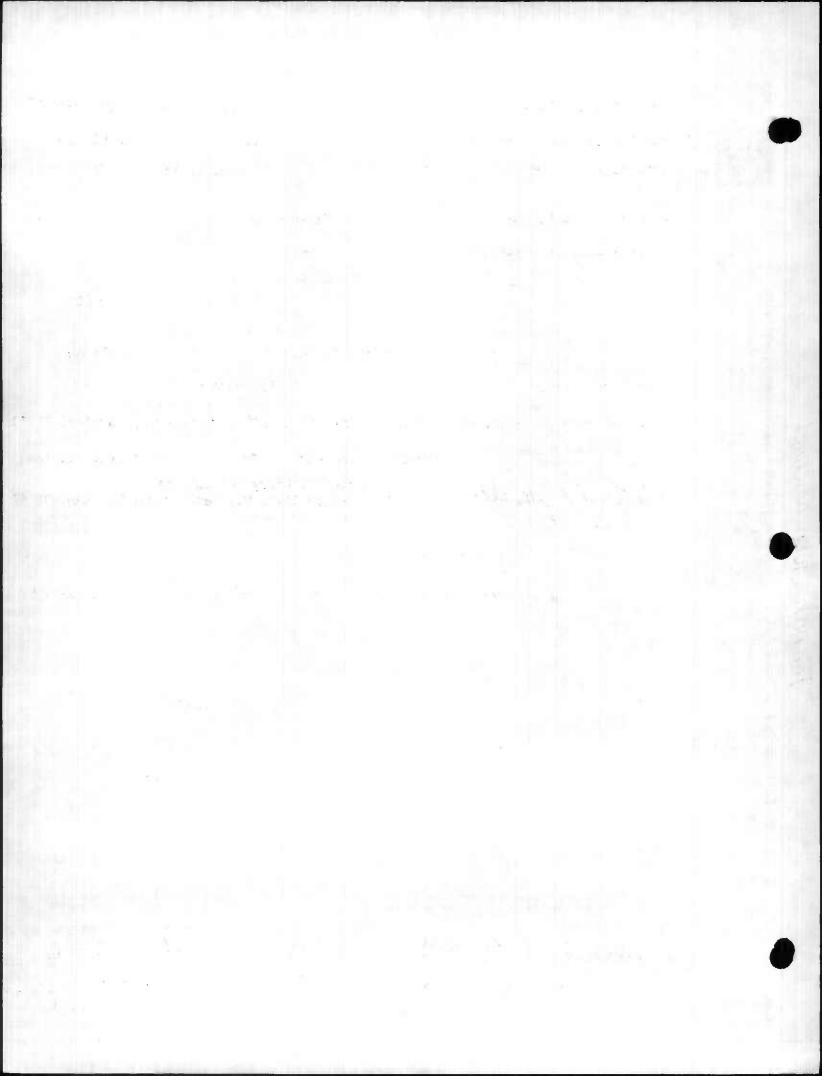
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Division of Vital Records,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 1998 **Physician** 1055 JOHN MICHAEL TEAHAN June /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Dey, Feb. 6, 5. Social Sacurity Number 9. Birthplace (State or Foreign **Funeral** 1 M 2□ F Days Hours New York 127-28-7763 62 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yas 2♥] No Washington Hagerstown Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or edical Examiner rount be r 21742 USA 20116 Cherry Hill Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is married other than "natural place. Funeral 12. Was Decedanf Evar in U,S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, While, atc. 1 Navar Married 2 Married 1 Yas 2 No Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Associate Professor College 18. Mother's Name (First, Middle, Melden Surname) 17. Father's Neme (First, Middle, Last) John James Teahan Julia Hassett 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 20116 Cherry Hill Drive, Hagerstown, Maryland 21742 Margaret Murphy Teahan, Wife 20a. Method of Disposition 20b. Place of Disposition (Nema of cemetery, crematory or other place) Date 20c. Location - City or Town, Stale 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Smithsburg Crematory June 9 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarai Saruto Lice 22. Name and Address of Facility
Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximata Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical P unonce **Examiner** Due to (or as a consequence of) Examine in oma Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) physician a the burial-Physician/Medical that initiated events resulting in death) Last Due to (or as a consequenca of): 23b. Did tobacço use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. š 1 Ves 2 No 3 Probably 4 Unknown signed to d be det þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an aulopsy Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificable 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2₽No 1 Inpatient 2 ER/Outpatient 3 DOA 200 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Naturel Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piace of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 朝 b Funeral D otaly filled hours Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29e. Certifier o the h within 24 h (Check only 29d. Dala signed (Month, Day, Year) 29b. Signatura and fitia of certifiar 29c. License number e and address of person who completed cause of death (Item 23a) (Type, Print) GSS LILWA deric 11110 medica 31. Date filed (Month, Day Year)
JUN 0 9 1998 32. Begistrar's Signature State

Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #23b,c,d,28b Per MEO Film G762 8-14-98RC Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of the **Physician** Month IDA MAE WEBER 4 1998 29 /Medical 4a. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. Ma Menty, 2at Year 921 5. Social Sacurity Number 214-32-4836 7. Aga (In yrs. last birthday) 9. Birthpleca (Stata or Foreign Marry Land **Funerai** 1 □ M 2 N F Director Usual Rasidence of Dacedant deeth with the Maryland 10a Stata 10b. County show 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28e-f sho the Modical Examiner must be nothed at **Funeral Director** Maryland Washington 1 ☐ Yes 2 No Hagerstown 10e. Street end Number 10f. Zlp Coda 10g. Citizan of What Country? 18006 Westfield Drive 21740 USA 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yes 2 ☐ No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11 Marital Status 14. Race - Amarican Indian. Black, Whita, etc. filed within 72 hours efter 1. Navar Marriad 2 Married 21215-0020 1 ☐ Yas 2 No Specify: If Yas, Giva Yaar or Datas: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) Collaga (1-4or 5+) permit. Peges 1 end 2 should be filed v Department of Heelth end Mentel Hygier Important: If Item 27 is marked other th any Injury or other traumatic event, this once. Homemaker Own Home Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surname) Be Ira Weber Barbara Martin 19a. Informent's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Isaac M. Weber, Brother 21533 Black Rock Road, Hagerstown, Maryland 21742 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Reiff's Church Cemetery July 2 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Füheral Service Lice 22 Nama and Address of Facility
Louglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 23a. Pert 1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onsat end Death Physician /Medical Immediate Causa (Final 92 disaase or condition resulting in death) Examiner Examiner Saquentially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaase or injury that initiated avants rasulting in death) Last Bud Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown signed by) Steoperocis þ Completed 24b. Were autopsy findings evailable prior to complation of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 22 No 2 No certificate funeral director, 25. Was casa rafarred to medical Be 26. Placa of Death (Check only one) exeminar? 1 Yas 2 No Hospital: 1 Nopatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To this 27. Mannar of Death 28a. Date of injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After 1 Natural 5 Panding invastigation 1 ☐ Yes → No 200 Accident

To the Hospital or Attending within 24 hours after death.

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Medical (Check only one) 29b. Signatura end titla of certifier

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28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Fallin Kitches

281. Location (Street and Number or Rural Route Number, City or Town, State) 18004 WISH eld Dr. Hugerstown, M)

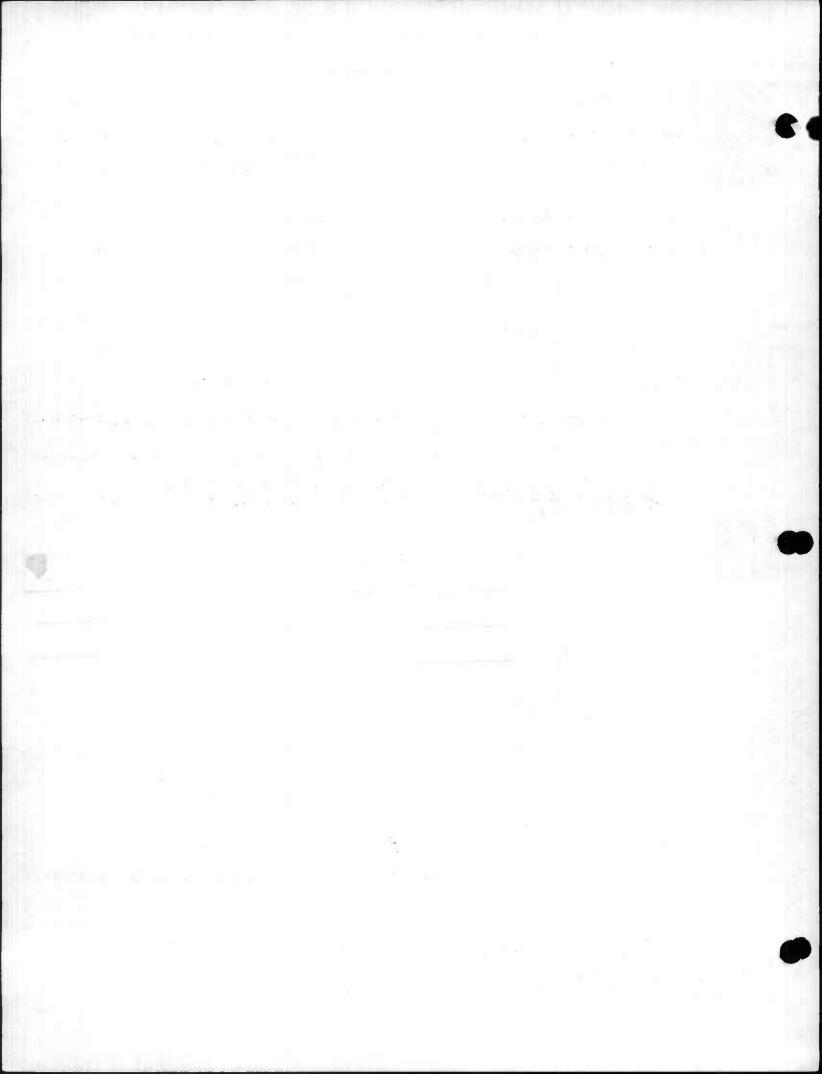
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| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, dete end place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed causa Quaath (ttam 23a) (Type, Print) Maller

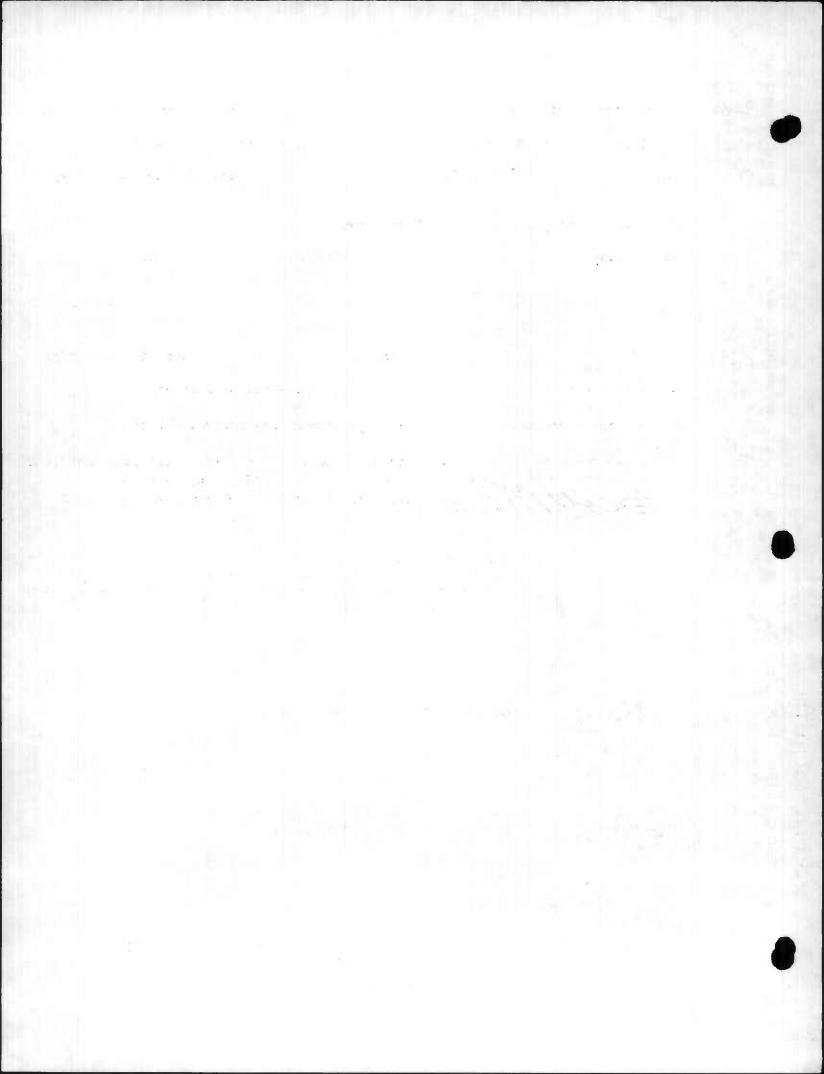
IIIW redica 32. Registrar's Signature 1998 Julia Davidson-Randell

State Registrar

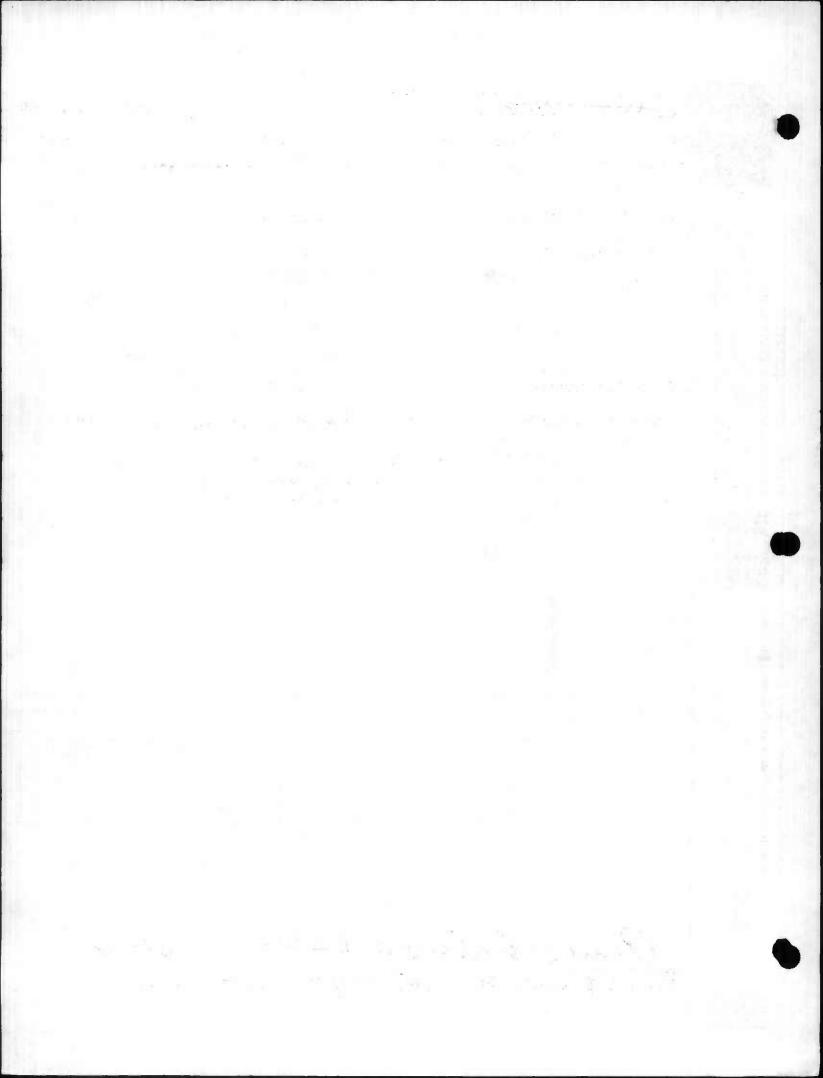


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Certifler (Check only one) 290. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 290. Date signed (Month, Dey, Yeer) 291. Date signed (Month, Dey, Yeer) 292. License number (Specify) 302. Name and eddress of person who completed cause of death (Item 23a) (Type, Pint)		See if a cau	mediate Ceuse seese or conditi- sulting in death) quentially list or ny, leeding to in use. 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	AMEND:	#1	Sta PER PHYSICIAN G762 8-27-98 W	-		artment of F <i>rtificate of</i>			giene Reg. No.	21464	
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	Exami		4a. Fecility Nama (If not institution, give street a Hartland Assisted Liv		ter		4b. City, Town, or Severna	Park	7	Anne Arrundel	
	Funeral Director		5. Social Security Number 217-12-1086 6. Sex 1□ M 2∑		yrs. last birthday) 79 Yrs.	If Under 1 Yaar Months Deys	If Undar 24 Hrs Hours Min.	8. Deta of Birt April 2	3'aar)1919	Birthpleca (State or Foreign Carpity) Maryland	מק
	Maryland a-f show	ctor	Usual Rasidence of Decedent 10e. Stata 10b. County Maryland Washingt	ocation I-	Magerstow	n		10d. insida City Limit: 1 ☐ Yas 2 💢 No			
	h with the	Funeral Director	10e. Street and Number 13233 Glendale Drive			10f. Zip Coda	21742		10g. Citizen of Wi	hat Country? USA	
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be not ited.		1 Never Merriad 2 Married 1 1	Decedent Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar in the second Evar	1	Was Decedent of H f Yas, apecify Cub 1 ☐ Yes 2 🛣 No	dispanic Origin? (S an, Maxican, Puer Specify:	pecify Yes or No- o Rican, atc.)	14. Race Bieck Specify:	- Amarican indian, s, Whita, atc. White	
21215-0020	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", reumetic event, the Mexical Exa	Completed by	15. Decedent's Education (Specify only highast grada comp. Elamantary/Secondary (0-12) Col.	eted) ega (1-4or 5+)	(Giva	dent's Usuel Occup kind of work dona DO NOT usa ratire HOMEN	during most of wo d)	rking	16b. Kind of Bus	sinass/Industry	
Maryland 2	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Nama (First, Middla, Last) Ambrose Loy Foreman			HORICI	18. Mothar's Na	na (First, Middla, 1son For	Maiden Sumama		
	1 and 2 sho Health and em 27 is me other traums		19a. Informant'a Name/Raiationship (Type, Prir Barbara Kight, Daught	er	163	ng Addrass (Street 33 Ardsle					
Baltimore,	Petry		20a. Method of Disposition 1 3 Buriai 2 □ Cramation 3 □ Ramovai 4 □ Donation 5 □ Othar (Specify)		Rest Ha	aven Ceme	etery	June 8	Hagerst	city or Town, State Lown, Maryland	£
Bal	permit. Pe Departmer Important: any Injury		21. Signature of Funeral Sarvica Licensaa	tin	133		n Blvd.	N., Hage	rstown,	Maryland 217	42
	Physician /Medical Examiner		234 Part1. Entar tha alsaasa for complications shock, or haart failura. List only ona caus immediata Causa (Final diseese or condition rasulting in death)	on each line.	ocard	id I			rast,	Approximata interval Between Onset end Deeth	
	oted d ensit	Examiner	b		to (or as a conseq						
68760,	ifficate be executed g physician and as the buriel-trensit	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated evants rasulting in death) Last		o (or as a conseq						
Box	death certifi e attending od for use as	Physician/M	d	to death but not	resulting in the u	ndarhing cause ah	van in Part i	23h Did t	obecoo use cont	tribute to the cause of death	. 2
s, P.O	requires that tha de been signed by the i hould be deteched	by Phys	Alz Leiner's Bereavener	101		3 Probably 4 Unknow					
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	ng Phys fler this pneral di	2	1 Yea 2 No Hospite! 27. Mannar of Death 1 Natural 5 Panding 2 Accidant invastigation	1 ☐ Inpatiant 2 Data of Injury (Month, Day Year	2 ER/Outpatien 28b. Tima of injury	28c. injur	4 LI Nursing F		anca 6 Other	1 . ,,	
Division	To the Hospital or Attendil within 24 hours after death. To the Funeral Director; A completely lilled in by the fu	Certification:				eat, factory, offica		City or Tow	n, Stata)	r or Rural Routa Number,	
	the Hosp in 24 hou the Fune	ledical		tha best of my tha basis of axan mannar atated.	knowledga, daath nination and/or inv	astigation, in my o	pinion, daath occu	, and dua to tha d rred at tha tima, d	causa(s) and man data and piace, ar	nar es stated. nd due to tha cause(s)	
9	To Too	M	29b. Signature and titla of certifiar	hol	Zer (m	29c. Licans		28 me		(Month, Day, Year)	
			30. Name and address of person who completed	s Mo	166/	Print) ay	tan Co	ente o	Cofty		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature Widson-Ran	dell					

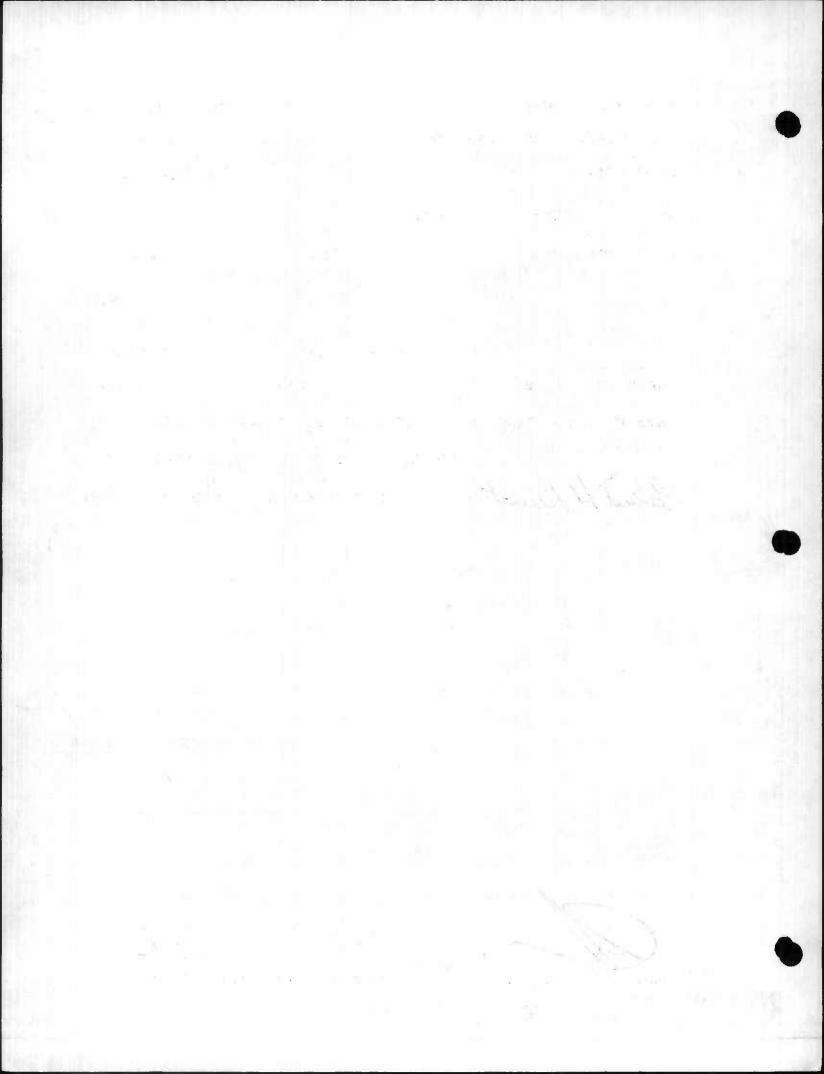


State of Maryland / Department of Health and Mental Hygiene

The law requires that the death certificete be executed P.O. Box 68760. Records,

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey **Physician** Month HELEN GRACE WAGNER JUNE 19, 1998 6:30 AM /Medical 4e. Feclify Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** GARRETT COUNTY MEMORIAL HOSPITAL GARRETT 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 20 F Deys Hours 207-32-3764 Yrs. Director PA Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified GARRETT OAKLAND 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ŏ 206 N. 10TH STREET 21550 itеms 23a USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is merked other than "natural", or item any injury or other traumetic event, the Medical Examine 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: by 3 N Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) SCHOOL TEACHER EDUCATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be **GEORGE** S. McDOWELL NORA 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) NORMA ROBINSON - NIECE 208 N. 10TH ST. OAKLAND, MD 21550 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from Stete LIGONIER VALLEY CEM. 6/23/98 LIGONIER, PA. 4 ☐ Donetion 5 ☐ Other (Specify) of Furnital Service License 22. Name end Address of Fecility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical Immediete Cause (Finel Intracerebral Hemmorhage 12 hours disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner bunal-transit Sequentielly tist conditions, if eny, leading to Immediate cause. Enter Underlying Couse (Diseese or Injury that Initiated events resulting In deeth) Lest Due to (or es e consequenca of): Physician/Medical the Due to (or es e consequenca of): is certificate has been signed by the a director, page 2 should be detached to Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Certification: To Be Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification properties of the funeral director; to completely filled in by the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturet 2 Accident 5 Pending Investigetion 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 29e. Certifier 区ertifying Phy Medical en: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and menner as stated. r: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner steted. 29b. Signature and title of 29c. License number 29d. Dete signed (Month, Day, Year) D23979 1221 rson who completed cause of deeth (Item 23e) (Type, Print)
oralski, M.D. 311 N. Fourth Street Robert A. Goralski, M.D. Oakland, MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JUN 23 1998 Registrar

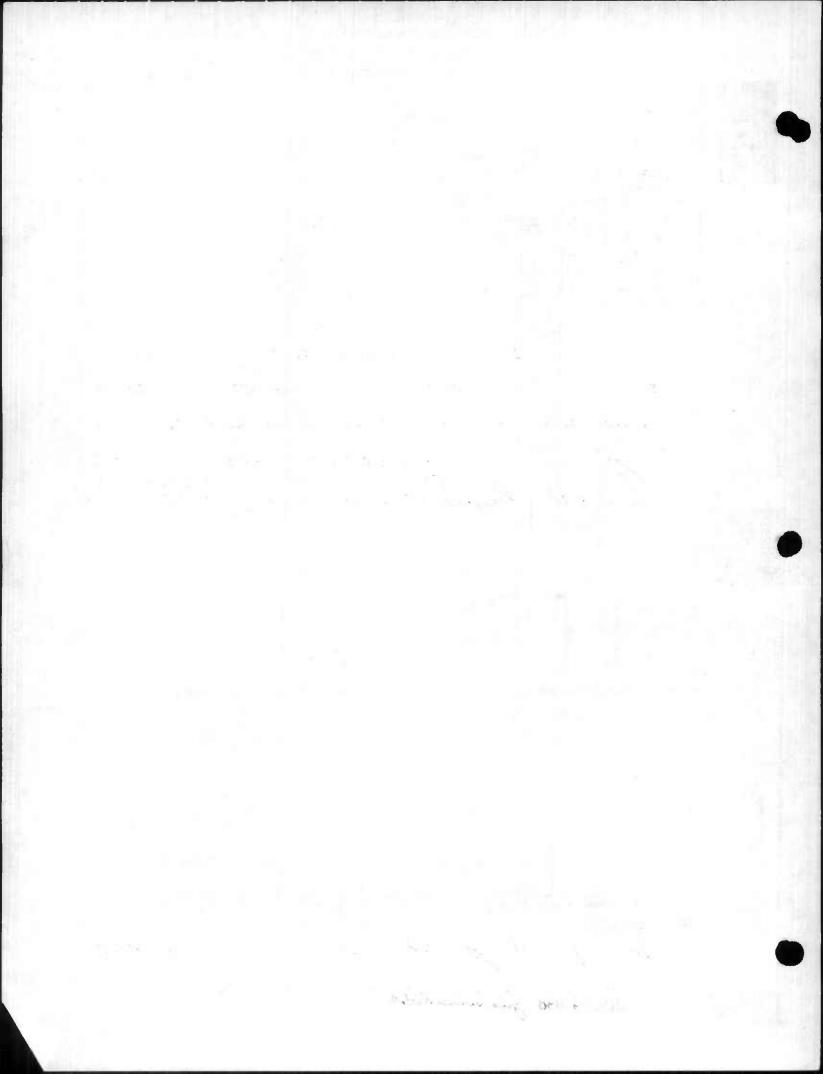


State of Maryland / Department of Health and Mental Hygiene

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	Dhualai		1. Decedant's Nama (First, Mi	t)				2. Data of Deat Month	h Day	Year	3. Tima of Death				
	Physici /Medio		Gladys Waller							June	28 19	17/	6;15 am		
	Examir		4a. Fecility Nama (If not institu	m <i>ber</i>)	4b. City, Town, or	Location of Death	4c. County								
			Deer's Head	d Cer	nter				Salisb	bury Wicomico					
	Funeral Director	Director	5. Social Security Number 6. Sex 1 M 2 X F 7. Age				ga (In yrs. last birthday) if Under 1 Year if Months Days if			8. Data of Birth (Month, Day,	Birth Day, Year) 9. Birthplaca (Stata or F Country)				
Baltimore, Maryland 21215-0020	D .		Usual Residence of Decedant							AUG.4,1902 MARYLAND					
	show		10a. Stata 10b. Cou	nty		10c. (City, Town or Lo	cation				10d.	. Insida City Limits		
	should be filed within 72 hours efter death with the Maryland rind Mental Hygiene. I have tracked other than "returel", or items 23s or 28s-f show urnatic evant, its Medical Exemple must be nothed a		MD	MICO			SALIS	BURY		1∭ Yes 2□No					
			10e. Street end Number					10f. Zip Coda		10g. Citizan of What Country?					
	ath v	rai	1030 E.	MAIN					21804			U.S.A.			
	after de	Funeral	11. Maritai Status 1 ☐ Navar Married 2 ☐ Marriad		12. Was Dacedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No			13. Wes Decedant of Hispanic Origin? (Spif Yas, specify Cuben, Maxicen, Puarto			14. Raca - American Indien, Bieck, White, etc.				
	ours e	Completed by	3 ☐ Widowad 4 ☐ Divorced			if Yas, Giva 1 Yeer or Detas:			1 ☐ Yas 2 📉 No Specify:			Specify: WHITE			
	be filed within 72 ho ital Hygiene. d other than "natur evant, tre Med cal		15. Dacedant's Education (Specify only highast grada complated)				16a. Deced	dant's Usuel Occu	pation during most of wo	16b. Kind of Businass/Industry					
	han		Eiamantary/Secondary (0-12) Collega (1-4or 5+								DICINE				
	e filed v al Hygie other ti vant, II.	S	17. Father's Nama (First, Midd		R	EGISTERE		ma (First, Middla, M							
	Mental Parked of	To Be	ERNEST	a, Lasi)		N	ICHOLS		MARGA						
	d 2 should be the ord Menta T is marked trsumatic ex		19e. Informant's Name/Relation	nship (T	voe. Print)	14		ng Address (Straa			ET TURNER Route Number, City or Town, Stata, Zip Code)				
	4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		G. HARLON			COUST			ARIS DR.	SALISBU			,		
	-125		20a. Method of Disposition			20b.	Place of Dispo	sition (Nama of natory or other pla			20c. Location -		, Stete		
	permit. Peges Department of Important: If its any injury or o		1 Burlel 2 □ Cramation 4 □ Donation 5 □ Other			Stata			,	6-30-98	SALT	SBIIRY.	MD		
aH			4 Donation Other (Specify) PARSONS CEMETERY 6-30-98 SALISBURY, MD 21. Signature of Edmaral Service Licensee 22. Nama and Addrass of Facility 705 E. MAIN ST.												
n	88 E 5 8		CALTONUNY AM 2100/												
			BOUNDS FUNERAL HOME SALISBURY, MD 21804 23a Part Y Entar tha disaase, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Batween Onset and Death												
	Physician /Medical Examiner														
		Examiner	Immediata Cause (Final disease or condition resulting in death) a. Pneumonia Dua to (or as a consequence of):												
														bed sit	
			al-tra	Exar	Sequentially list conditions, if any, leading to immadiate		-		(or as a consac						
68/60 ,	death certificate be executed e ettending physicien and ed for use es the burial-transit	edicai	Sequentially list conditions, if any, leading to immediate course. Enter Undarlying Cause (Disease or injury that initiated events Dua to (or as a consequence of): Chronic obstructive pulmonary disease Years Dua to (or as a consequence of):												
Q	g phy es th	Pa	resulting in death) Last Dua to (or es e consequence of):												
gox	endin r use	Physician/M	d.												
	deat he ett ed fo		Part II. Other significant cond	tions cor	ntributing to de	eath but not ra	sulting in tha u	nderlying cause gi	ivan in Part i.	23b. Did to	bacco uas co	ntribute to th	es cause of death?		
5	et the d by the etache	Phy	Alzheimer's type dementia, Hypertension							1 🗆 Yı	8 2 No	3 Probab			
Ś	igned bed	by		0715	- denie	ile id / i	ily per ce.	1151011					Х		
Records,	v requires that the death cer been signed by the ettendin should be detached for use	eted	Mass in the left breast 24a. Wes an autopsy performed?								evelia	autopsy findings			
ec C	law has b e 2 sl	Be Completed								of das	letion of ceuse ath?				
_	sician: The law s certificate has b director, page 2 s									1 □ Ya	s 2 No	1□Y	es 2□ No		
VITAI	iclan certifi recto		25. Was cesa rafarred to medi axaminar?		lospital:			_ Ot	hom	eth (Check only on					
5	Phys ral di	-T	1 Yes 2 No 27. Mannar of Death		28a. Data d		☐ ER/Outpatien 28b. Tima of	1 3LI DON	4 LI Nursing F	lome 5 ☐ Rasida 28d. Dascriba ho					
VISION	th. : After e fune	Itlor	1 Dslatural 5 Panding (Month, Day Year) injury Work?						ork?]Yas 2 □ No						
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5	s after si Dir.	Certification:								City or Town	City or Town, Stata)				
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	Registr	_	JUNA	7 177	175	-									

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth Dey **GEORGE** THOMAS WINEBRENNER, JR.

3. Time of Deeth

0245

MD.

WHITE

10d. Inside City Limits

21804

Approximate fntervei Between Onset and Death

1 Yes No

Examiner the Meryland ma 23a or 28a-f ahow with deeth items 2 7 is merked other then "natural", or iten traumatic event, the Western Examples 72 hours after Pages 1 and 2 should be filed within nent of Health end Mental Hygiene. altimore, Maryland if item 27 or other tra

inebreno

Physician

/Medical

Funeral Director Director Funeral p Completed Be permit. Page Department **Physician** /Medical Examiner Examiner The law requires that the death certificate be executed physician s the burial P.O. Box 68760, Physician/Medical attending pl signed by the at id be detached for Records, þ Completed page 2 certificate Division of Vital Hospital or Attanding Physician: director. 86 P this funeral Certification: After after death. in by 24 hours a completely filled edicai within 2 To the 30. Neme and eddress of person who completed ceuse of death (Item 23e) (Type, Print)

1. Decedent's Neme (First, Middle, Last) 06 24 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) MAY 29,1926 If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1**∑**M 2□ F Deys Months 72 220-14-2483 Usuel Residence of Decedent 10e. Stete 10c. City. Town or Location 10b. County MD. WICOMICO SALISBURY 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1823 MT. HERMON ROAD 21804 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Wes Decedent Ever In U,S. Armed Forces? 11. Meritei Status Bleck, White, etc. 1X Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) RETIRED GUNNER U.S. NAVY 17. Fether's Neme /First Middle Last 18. Mother's Name (First, Middle, Maiden Surname) GEORGE THOMAS WINEBRENNER, SR. MAUDE ELIZABETH HUBBARD 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) MAUDE E. WEHNER-MOTHER 1823 MT. HERMON ROAD, SALISBURY, MD. 21804 20b. Piece of Disposition (Name of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete SPRINGHILL MEMORY GARDENS6/26/98 HEBRON, MD. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee BOUNDS FUNERAL HOME, 705 E. MAIN ST., SALISBURY, MD. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finel ASCVI disease or condition resulting in deeth) Due to (or es e consequence of) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as e consequence of): 23b. Did topacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 12X Yes 2 No 3 Probably 4 Unknown IDDM 24e. Wes en eutopsy abrew Abuse

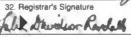
24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 Yes 20 No 25. Was cese referred to medical 26. Plece of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Meturel Injun 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner steted. 29e. Certifier 29b. Signature and title of certifie 29d. Dete signed (Month, Day, Year) 29c. License number

Registrar

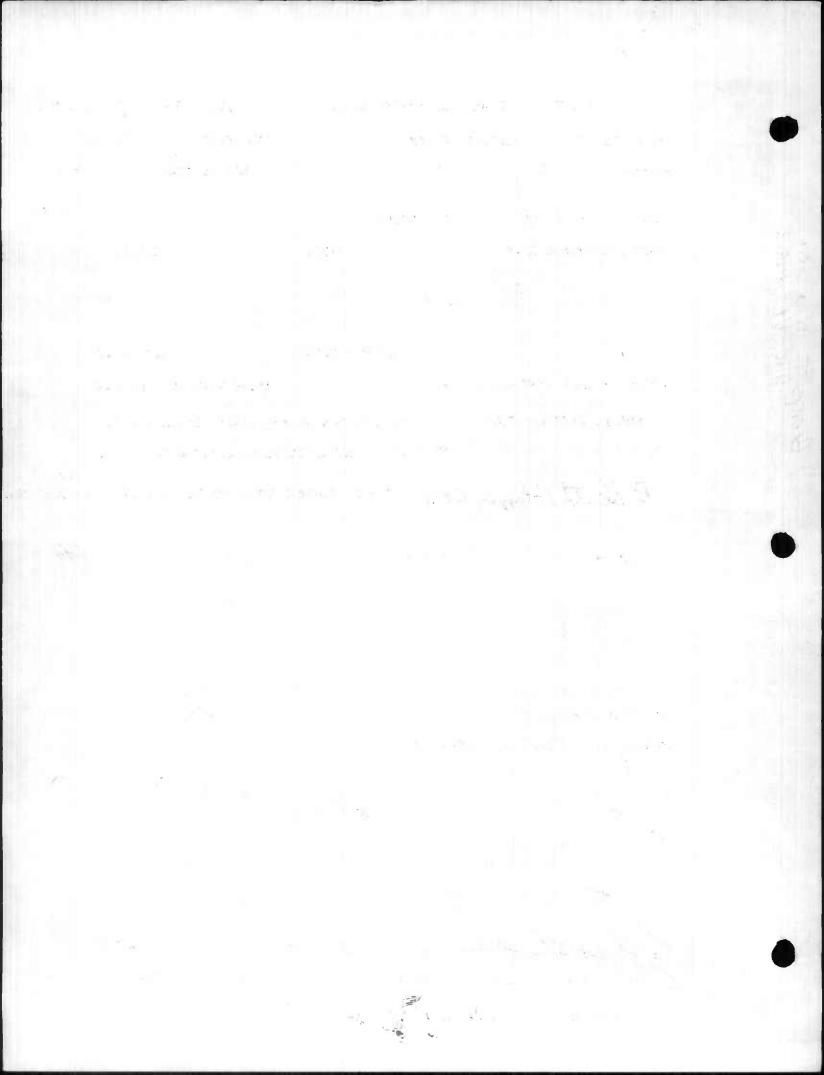
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31. Dete filed (Month, Dey, Year) JUN 26 1998



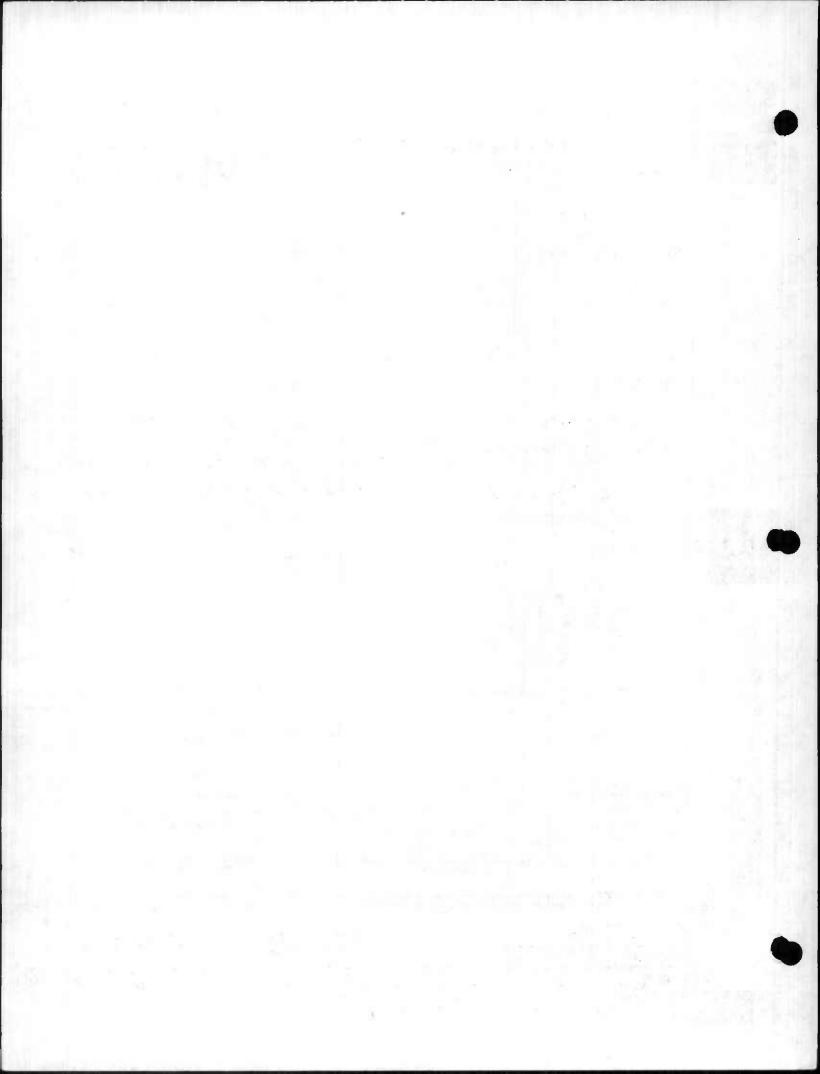
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State of Maryland / Department of Health and Mental Hygiene

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020 urs efter dea ai', or items Examiner m	b	11. Marital Status 1 Nevar Married 2 Married 3 W Widowed 4 Divorced 12. Wes Dacedent Ever in Amed Forces? 1 Yes 2 No If Yas, Giva Yaar or Deles:					fas Decedent Yes, specify (☐ Yes 2 🛛	of Hispanlo Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or Ne erto Rican, etc.)	No- 14. Race - American Indien, Bleck, White, etc. Specify: white				
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumstic event, its Medical Evantiner must be notified at	Completed	(Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+)						cupation ne during most of v tired)	16b. Kind of Business/Industry					
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Baltimore, permit. Peges 1 at Department of Hee Important: If Item 3	dike	4 Donetton 5 Other (Specify) Woodlawn Cemetery, June 22, 1998 Wilkinsburg, PA 21. Signeture of Funeral Servica Licensee 22. Name and Address of Fecility												
2024		Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 21536 Approximeta Interest on Homes of dying, such as cardiac or respiretory errest, Interest Between Interest Between Interest Between Interest Between Interest and Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph Deeph												
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To the Hospital or within 24 hours ef To the Funeral Di completely filled in	edical	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the ceuse(s) and menner es steled. 2 Medicaf Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and manner stated.												
To the To the Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commercial Commerci	×	29b. Signature and 159	S certifier				29c. Lie	26/J	4	29d. Deta signe	di (Month,	2)		
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S	ate	31. Vate filed (Month, I	Day, Year)	32. Registre	or's Signatur	10	t							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) JULY 10, **Physician** Lillian Μ. Adams 1998 8:45am /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Pasadena 7810 Catherine Avenue If Under 24 Hrs. Birthplace (State or Foreign Country) If Undar 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 10M 2 F Months Days Hours 89 Yrs. 216-60-9889 AUG. 12, 1908 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits then "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 Yas 2 No Maryland Anne Arundel Pasadena Directo 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 21122 USA 7810 Catherine Avenue Funeral 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Reca - American Indien, 12. Was Dacedant Evar in U,S. Armed Forces? 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yas, Give Yeer or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🗓 No Specify: þ 3 Widowed 4 □ Divorcad White "natural" Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 8 17 Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fit ment of Heelth and Mental Heart: If Item 27 Is marked oth jury or other traumatic even Emma Klofkey William Peach 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 7810 Catherine Avenue Pasadena, MD 21122 Carolyn Peach Burton/daughter 20b. Plece of Disposition (Nema of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any Injury or 7/11/98 Metro Crematory Inc. Baltimore, MD 21. Signature of Funeral Service Licensee Dawn F. McDonald Cremation Society of Maryland Inc. 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onsat end Deeth **Physician** Aspiration Pneumonia /Medical Immediete Ceuse (Finel disaase or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Examiner Alchemer's Disease physicien and the buriel-transit that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequenca of): P.O. Box 68760 Physician/Medical Due to (or es e consequença of): for use as signed by the a d be deteched for Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dewbitus ulcers Anemia Division of Vital Records, by 24b. Were autopsy findings available prior to Sepsis, rewrent Completed 24a. Wes an autopsy , urinary tract completion of cause of death? page 2 s infection, recurrent Cachexia 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Mospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifica 25. Was case referred to medical axaminer?

1 Yes No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OL 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigetion To the Hospital or Atter within 24 hours efter des To the Funeral Director completely filled in by th 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner stated. 29e. Certifier edical (Check only one) 29b. Signeture end title of certifier 29c License number 29d. Dete signed (Month, Day, Year) Candace I. Cherdler MD 7/11/98 D29209 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) CANDACE CHANDLERMD

State Registrar

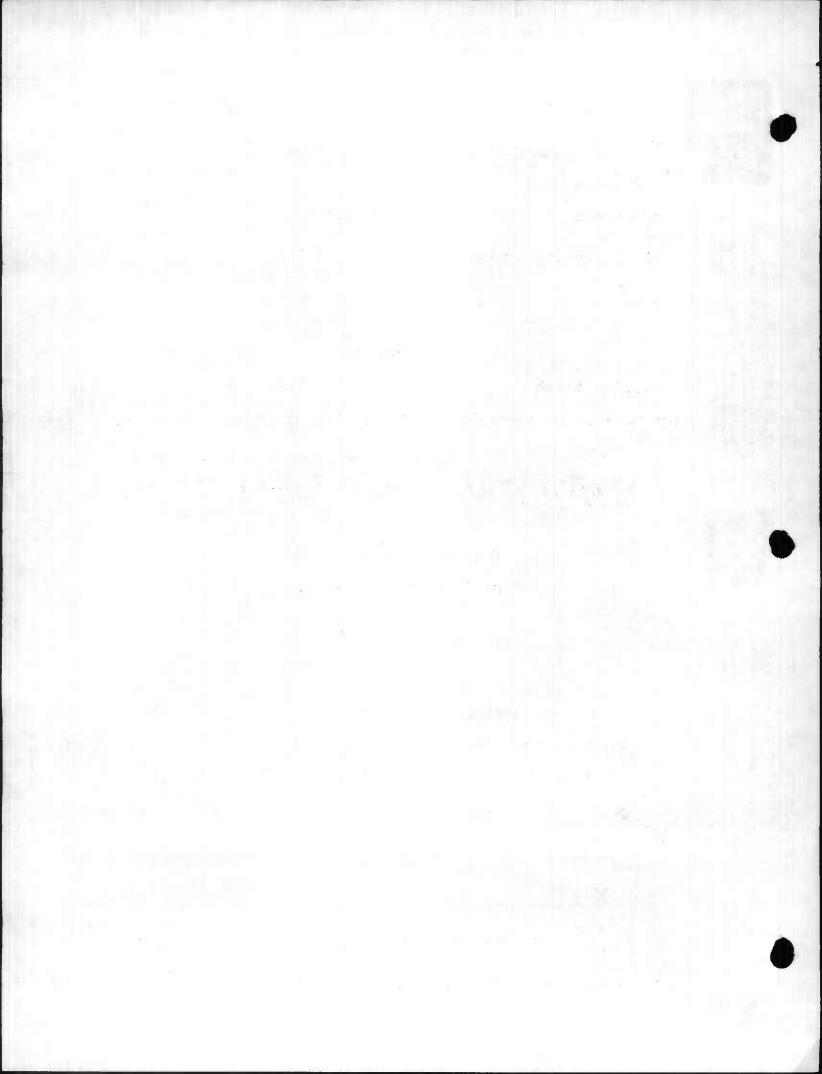
31. Deta filed (Month, Dey, Year)

JUL 1 4 1998

Fdwin



21122



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Tima of Death William Month Allen arcel City, Town, or Location of Deeth 08 4a. Facility Neme (If not institution, give street end number) 4c. County of Death Medical Anndel Anne Arundel Center MD n MA/8/AL If Under 24 Hrs. If Under 1 Yee 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Birthplace (Stete or Foreign Country) Min. Davs Houre 212-38-8350 59 Maryland Usual Residence of Decedent 10e. State 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Severna Park 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Manor Road 21146 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☒ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Machinist Paper Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) Marcellus William Allen Mary Magyar 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valarie L. Atwood/daughter 7846 Red Lion Way Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burlel 2 ACremation 3 ☐ Removal from State Metro Crematory, Inci. 7/10/98 Baltimore, MD 21. Signeture of Funeral Service Ucenset

The write F. McDona 4 ☐ Donetion 5 ☐ Other (Specify) 22 Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Abdommal Catastrophe / bleeding probable
Due to (or as e consequence of): Massive heratic metas tases

Due to (or as a consequence of): Recurrent Wetastatic Adunocortical Cancer
Due to (or es e consequence of): enowheal lances Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Wes an autopsy performed? 24b. Were autopsy findings avallable prior to completion of cause of death? 2 1 No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

Physician /Medical Examiner

ettending physician and for use as the burlel-transit

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certificate hes

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Hospital c 24 hours at

To the F within 2.

funeral director,

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

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Completed

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Certification:

edical

Physician

/Medical

Examiner

MD

Director

Funeral

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Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

deeth with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours effer dee Dependent of Health and Mental thygiene. Important: If feer 27 is merked other many injury or other traumers.

Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 C Sulcide Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

D30110

Registrar

BILG 10, RM 12 31. Date filed (Month, Dey, Year)

(Check only one)

29b. Signature and title of certifier

1 4 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Prigt 10, RM 12 N226

9000 Rockville 32 Registrar's Signature

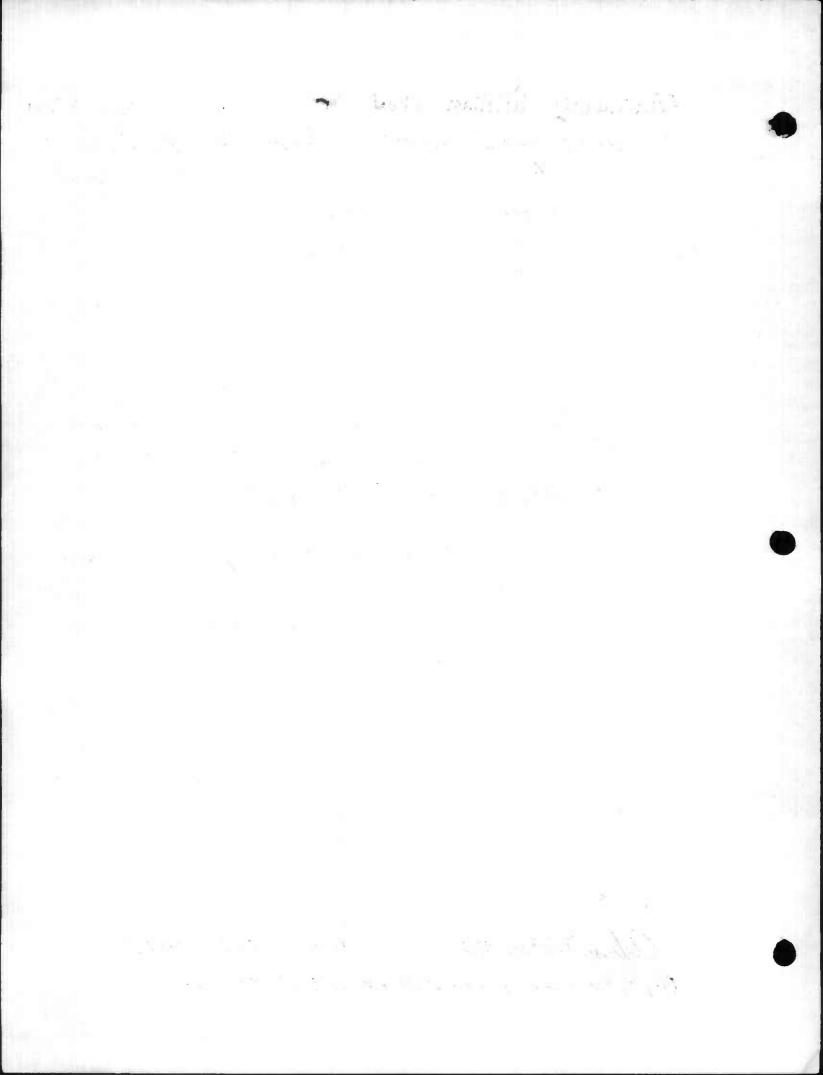
ike Ketherda MD 2,892

MD)

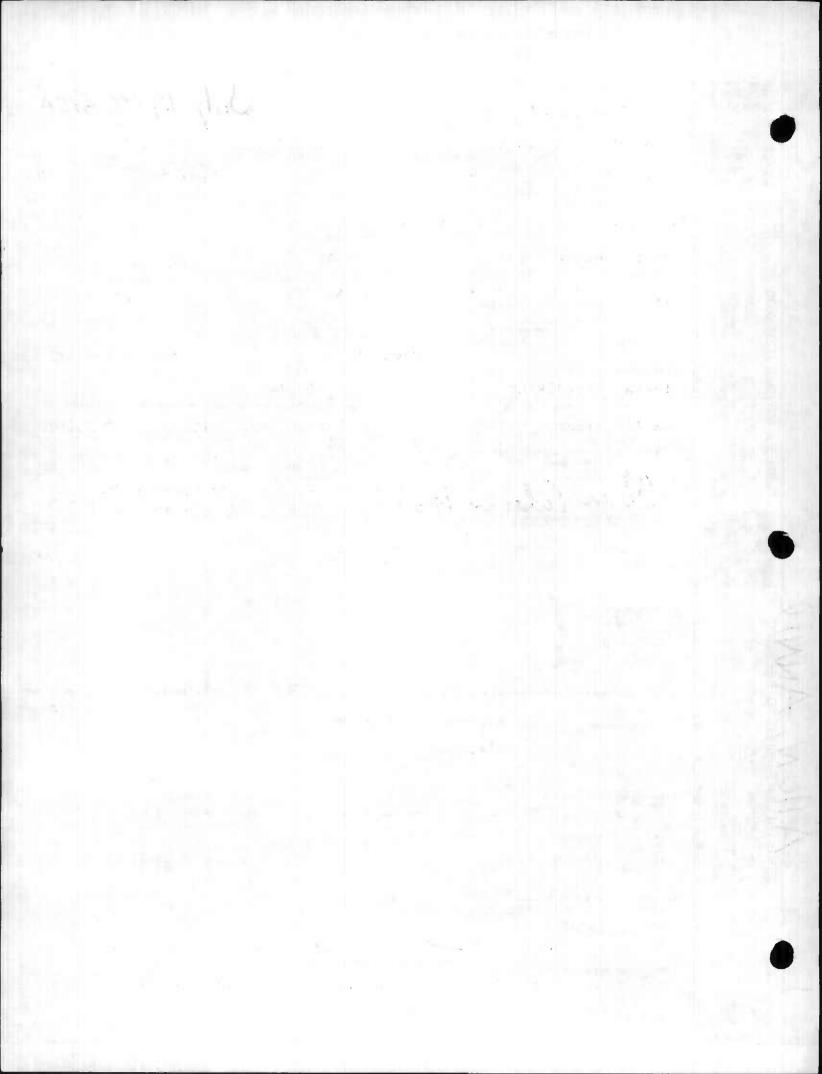
29d. Date eigned (Month, Dev. Year)

98

DHMH 16 Rev 6/95



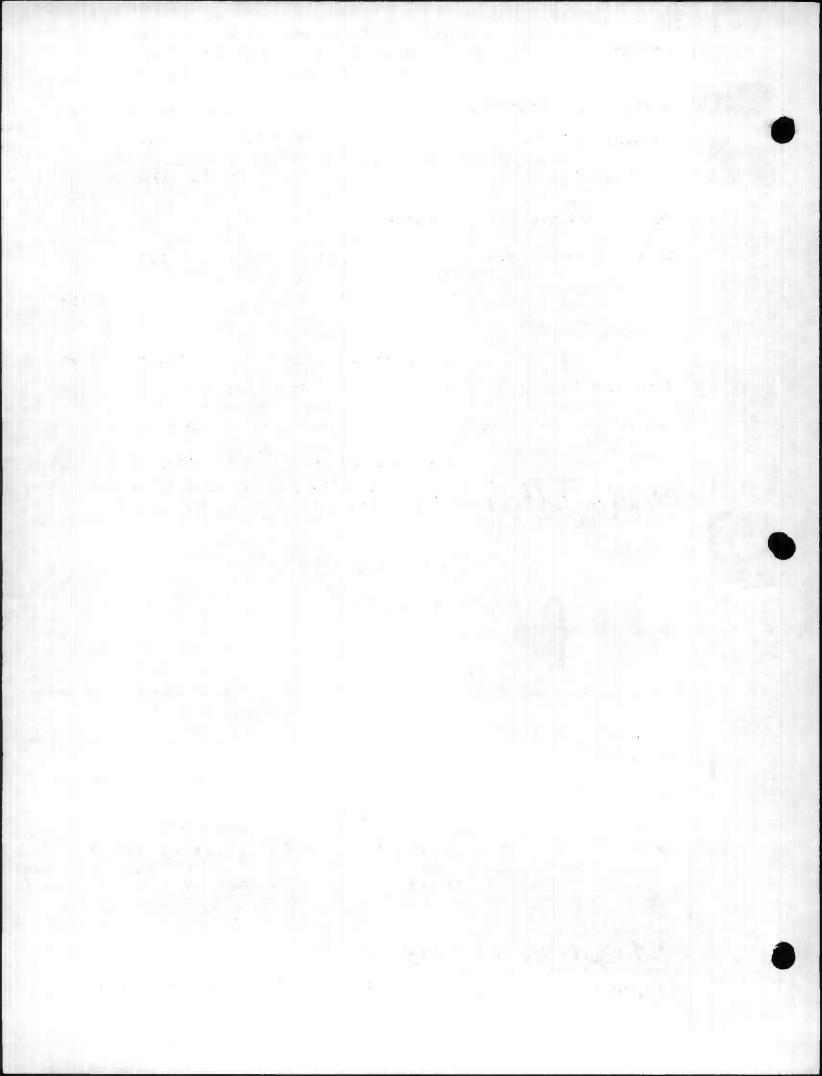
		State of N		epartment Certificate	of Health and M of Death		g. No.	214/1
	Physician /Medical	1. Decedent's Name (First, Middle, Last) ANNIE BELL ALLEN			4	Month y	90,19	3. Time of Death 545A
	Examiner Funeral Director	4a Facility Name (If not institution, give street and number Levindale Geriatric (5. Social Security Number 6. Sex 7. A 213-34-3088	Center Age (In yrs. last birtho	Months	4b. City, Town, or Lo Baltimor Year If Under 24 Hrs. Days Hours Min.	/	4c. County of N / Yeer)	
	w m	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	th with the Marylan 23s or 28s-1 show us! be notified at ral Director	Maryland N/A	Baltim	ore				ND Yes 2□ No
	with the Ma a or 28a-f e lbe notified	10e. Street and Number		10f. Zip C			0g. Citizen of W	het Country?
020	Pages 1 and 2 should be filed within 72 hours after death with the Manyland net of Health and Mental Hygiens. nt: If item 27 is marked other than "natural", or items 23s or 23s-f show nt: If item 27 is marked other than "natural", or items 23s or 23s-f show nt: If item for the factor other treaming a notified a rotted at the contract of the Completed by Funeral Director.	2606 Beethoven Aven 16 11. Marital Status 1 Never Married 2 Married 1 Yes 20 If Yes, Give Year or Dates	nt Ever in U,S. 3? (No	2 1 2 (13. Was Deceder If Yes, specify	nt of Hispanic Origin? (Spe Cuban, Mexican, Puerto	city Yes or No- Rican, etc.)	Black	- American Indisn, c, White, etc.
21215-0020	ed within 72 hourygiene. Nor than "netura it, the Wedical E.		16a. D	ecedent's Usual Give kind of work ife. DO NOT use	Occupation done during most of working retired)		16b. Kind of Business/Industry Private Family	
קַּ	tal Hygi d other event, I Be C	17. Father's Name (First, Middle, Lest)	DOM	CBCIC	18. Mother's Name			
ylaı	s 1 and 2 should be filed if Haalth and Mental Hyg fem 27 is marked other other treumatic evant, To Be C				Elvie			
Mar	ith and 17 ie m	19a. Informant's Name/Relationship (Type, Print) Hallie Allen			Street end Number or Rura			
	Pages 1 annent of Healunt: If Item 2	20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)	cemerery,	cremetory or other	choven Ave			
Balt	permit. Pages Department of Important: If it eny injury or once.	21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that ceus-	Jones .	Marshal	Address of Facility I W. Jone: Imondson A	s,Jr Fu ze. Bal	ineral	Home PA
	Physician	23a. Part1. Enter the disease, or complications that ceus shock, or heart failure. List only one cause on each	ad the death. Do no line	t enter the mode	of dying, such as cerdiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	ASCV	0			2753.
2	cata be axecuted physician and s tha bunal-transit	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):				
N X X Segre		that initiated events resulting in death) Last	Due to (or as e con	nsequence of):				
0	at the death certi	Part II. Other eignificant conditions contributing to death	but not resulting In t	he underlying cau	use given in Part I.			tributa to the cause of death?
S, B	igned by be datac by Ph	asp	vation !) NTUMO	1	1 🗆 Y	es 2 No	3 Probably 4 Unknown
<00	ple	1/e	us l			24a. Was a perform	n autopsy ned?	24b. Were autopsy tindings available prior to completion of cause of death?
\ A =	cartificate ha rector, page					1□ Ye		1 ☐ Yes 2 ☐ No
7	Physician: this cartific ral director, To Be	25. Was cese referred to medicel examiner? 1 Yes 2 No Hospital: 1 Inpa	tient 2 ER/Outp	patient 3 DOA	28. Place of Death Other: 4 Nursing Ho			er (Specify)
7 5	g the C	27. Manner of Death 1				28d. Describe ho		
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	Ne Hospin 24 hours Funein Pletely file	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner:	of examination and/					
_ ((Me Comp	29b. Signature and title of certifier		29c.	License number	2	9d. Date signed	1 (Month, Dey, Year)
0					037573		Zuk	10,1998
1		30. Name and address of person who completed cause of Section 1727	0 Park	Height	. Ave P	oaltime	o Mi	71708
100	State Registrar	31. Date tiled (Month, Dey, Year)	strar's Signature	2				



SCOTT M. ACKERMAN

State of Maryland / Department of Health and Mental Hygiene

			Decedent's Name (First, Middle, La.	et)		Certificate of	Death	2. Date of Deat	eg. No.	t.	3. Time of Deeth				
	Physici	an		Ackerman				Month	Day	Year	0. 14110 01 50041				
٠.	/Medic		4a Facility Name (If not institution, gin				4b. City, Town, or L	JULY ocation of Death	12 1 4c. County	998	12:20 A				
A	Examin	er	BAYVIEW HOSPI	TAL			BALTIMO	RE	N/A						
	Funeral Director			Sex 7. Age	e (In yrs. last birt	(thdey) If Under 1 Year Months Deys		8. Dete of Birth (Month, Day, May 2,		9. Birthpi Coun MD	lace (State or Foreign try)				
	and w		10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits				
	Aaryl f sho	5	MD Balti	more	Dur	ndalk					1 ☐ Yes 2 🔀 No				
	the 128s	9	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhet Coun	itry?				
	death with the Maryland ms 23s or 28s-f show cross be notified at	Funeral Director	2976 Sollers	Point Rd		2122			USA						
	Tre 2	era	11, Marital Status	12. Was Decadent	Ever in U,S.	13. Was Decedent of If Yes, specify Cul		pecify Yes or No-	14. Rac	e - Americ					
0200-612	or ite	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ h If Yes, Give Year or Detes:	No	If Yes, specify Cul		Rican, etc.)	Specify		White, etc. White				
5	72 hours natural',	Completed	15. Decedent's E (Specify only highest gr	ducation	16a.	Decedent's Usual Occu	ipation	kinn	16b. Kind of Bu	usiness/Inc	dustry				
7	within 7 ene. than *r	ple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	(Give kind of work done lifa. DO NOT use ratin	ed)	(iii)g							
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yland	be filed tal Hygid d other event, the	Be	17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme)												
<u>₹</u>		2	John E. Acker					Kroplir	Yes						
Маг	0		19a. Informent's Name/Relationship	•		Mailing Address (Street			, City or Town,	State, Zip	Coda)				
e, a	s 1 and f Heelth frem 27 other tr		Brenda Ackerm	an /wife		76 Soller	rs Point		ltimo	re,	MD 21222				
0	I of H		20a. Mathod of Disposition 1 ☐ Buriai 2 ☒ Cremation 3 ☐	Removal from State	cemeter	Disposition (Name of y, cremetory or other pl	o u	ly 13	20c. Location -	City or To	wn, State				
	Part:		4 ☐ Donation 5 ☐ Other (Speci		Metro	Cremato	ry		Catons	vill	e, MD				
Saitimor	permit. Pages I Department of H Important: If Ne any Injury or ot		21. Signature of Funeral Service Lice	nsee	0.1	22. Name and Add	ly Funer	al Home	of Di	ında	lk				
	00540		Untlong Co	et in	nelly		ollers P								
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plicetions that caused one ceuse on each lin	the death. Or ne.	not enter the mode of dy	ring, such as cardiac	or respiratory err	est,	1	Approximate Interval Between				
1	Physician		J		U						Onset and Death				
4	/Medical Examiner		Immediate Cause (Final disease or condition	a. Mu	Hioly	injur	14 <								
	LAGITICI		resulting in death)	u	Due to (or as e										
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	end end I-tran	Examiner	Sequentially list conditions,		Dua to (or as a d	consaquance of):									
Ď,	clan buria		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	C											
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j	y the check	ysi	Part II. Other significant conditions	contributing to death be	ut not rasulting in	the undarlying cause g	iven in Part I.				the cause of death?				
7	that the							1 U Y	es 214No	3 □ Prol	bebly 4 Unknown				
cords,	requires ween sign hould be	d by						24e. Was a	in autopsy		ere autopsy findings				
Ö	- 40 (0	ete						perfor	med?	CO	ailable prior to impletion of cause				
Le	hes b	Completed						~	• • •		death?				
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	Hospital 14 hours Funeral 19ly filled		29a. Certifier 1☐ Certifying Pf	ysician: To the best of	of my knowledge	, death occurred at the	tima, data and plece	end due to tha c	ause(s) and ma	annar as s	ary land				
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	2426	Me	29b. Signature and title of certifier			29c. Licer	nse number	2	9d. Date signe						
	VO.		Alinh	A 1/	molo	2 MD 0.1	C.M.E		JULY	12,19	998				
1	=		30. Name and address of person who	complated causa of d	eath (Item 25a)	Type, Print)									
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		1. Decedent's Name (First, Middle, Last)		-		-	2. Date of Deat	h	3. Time of Death
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/Medic Examin		4e. Facility Name (If not institution, give s.				4b. City, Town, or L	1 . 5	4c. County of Deeth	1 701.
LAGITHI	ici	Church Home Ret	irement Co	ntor		Baltim	0.00		
Funeral	1	5. Sociel Security Number 6. Sex	7 Age (In vrs		If Under 1 Yea	r If Under 24 Hrs.	8. Date of Birth	N/A	poiace (State or Foreign
Director		222-16-8765	M 212 F 87	Yrs.	Months Day	Hours Min.	(Month, Day,		npiace (State or Foreign untry)
		Usual Residence of Decedent	07				AUG. 11	, 1910 De	laware
ylan how		10e. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Me Tal	to	Maryland N/A			Balt	imore			1 Yes 2 No
with the Meryland a or 28a-f show be notified at	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of What Co	untry?
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death erms 23	Funeral	11. Maritel Stetus	2. Was Decedent Ever in U. Armed Forces?	S. 13. \	Wes Decedent of	Hispanic Origin? (Sp ben, Mexican, Puerto	ecity Yes or No-	14. Race - Amer	
or h		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 📉 No If Yes, Give		Tes, specify Cu		rican, etc.)	Biack, White	, etc.
rel:	i by	3 ₩ Widowed 4 Divorced	Year or Dates:		1 163 2X-140	э эрөску.		Specify:	White
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should by nd Menta marked imatic ev	To	William Hughe		-				e Bastia	
d 2 should th and Mer 7 is marke traumatic		19a. informent's Name/Reletionship (Typ		19b. Mailir	g Address (Stree	et and Number or Rui	ral Route Number,	City or Town, Stete, Z	ip Code)
s 1 and f Health tem 27 other t		Suzanne B. Crowd				ee Place			
ges it of h		20a. Method of Disposition 1 □ Buriel 2 □ Cremation 3 □ Re		em <i>etery</i> , cren	sition (Name of netory or other pi	ace)	Date 2	20c. Location - City or 1	fown, State
ment:		4 ☐ Donation 5 ☐ Other (Specify)	Met	ro Cre	matory,	Inc. 7	/14/98	Baltimon	ce, MD
permit. Page: Department of important: If i any Injury or page.	li	21. Signature of Funeral Service Ligenbee	1ch malal	22	Name and Add	ress of Facility	twof M	aryland 1	T
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		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death	n. Do not ente	er the mode of dy	ring, such es cardiac	or respiretory arre	est,	Approximate Interval Between
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e des	Sic	Part II. Other significant conditions contri	ibuting to death but not resu	ulting in the ur	nderlying cause g	iven in Part I.	23b. Did tot	pacco use contribute	to the cause of death?
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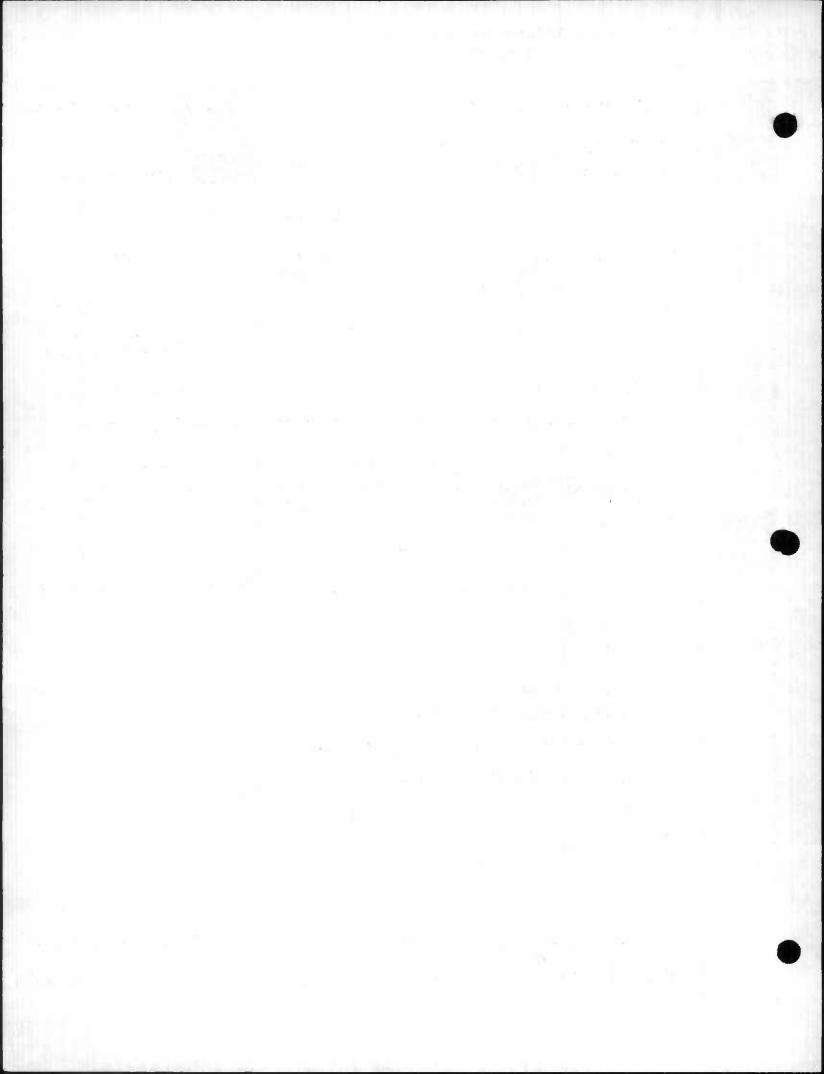
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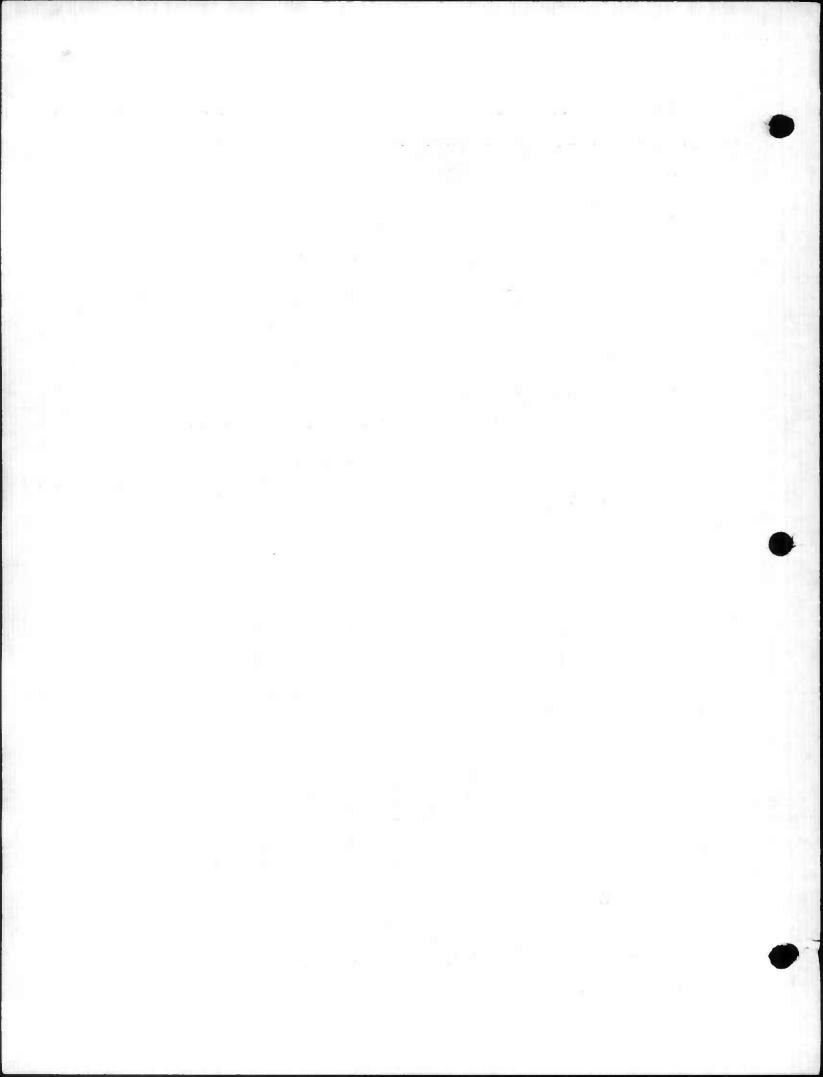
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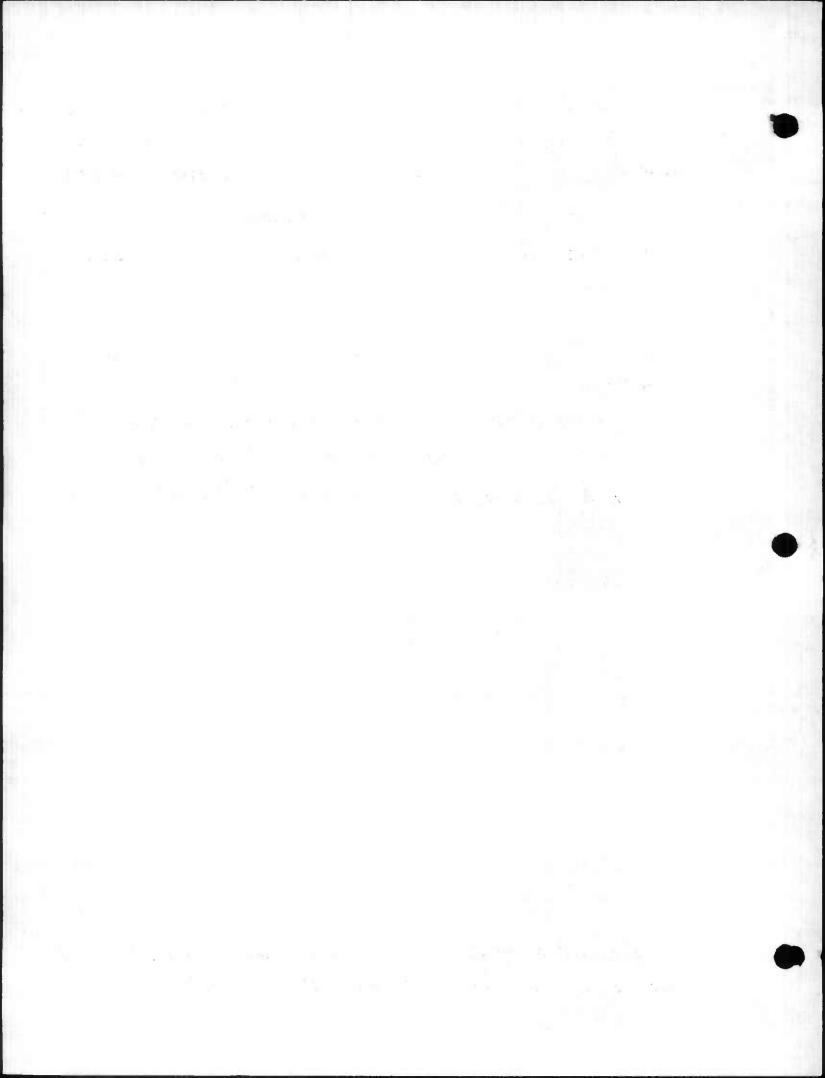
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State of Maryland / Department of Health and Mental Hygiene

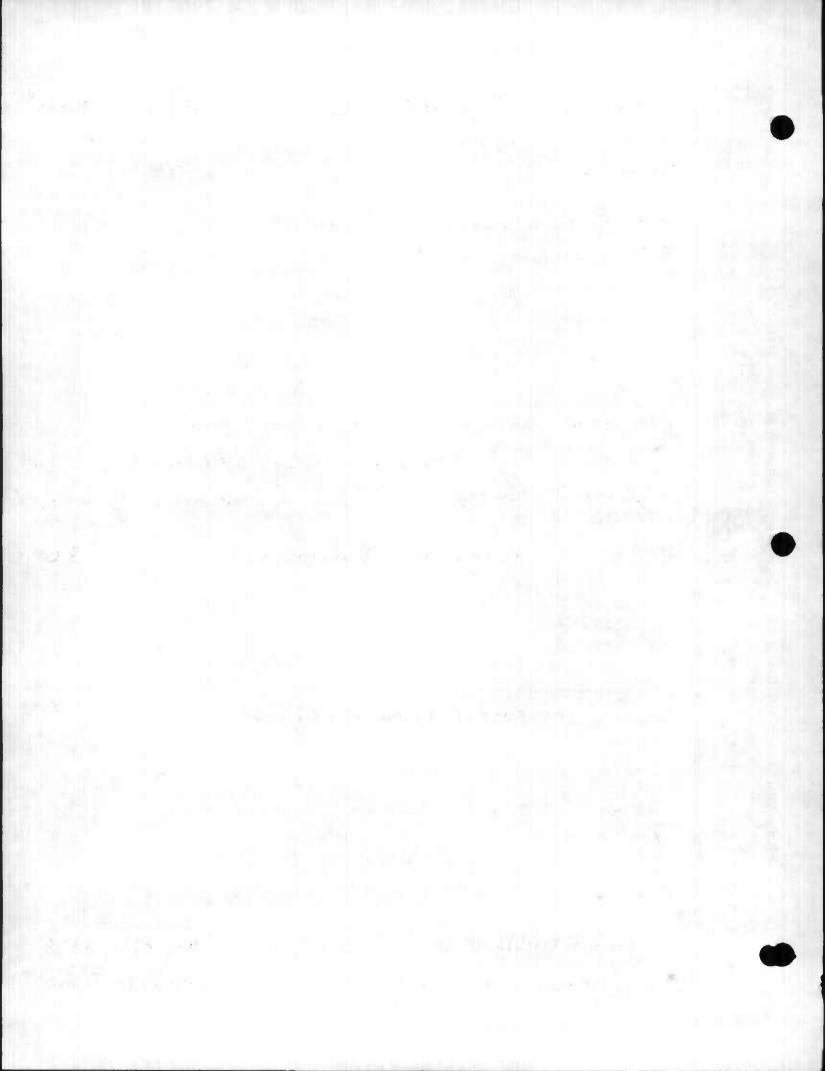
Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month **VIRGINIA** BUSH 9, JULY 1998 2:30 PM /Medicai 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 8530 DOGWOOD ROAD WOODLAWN BALTIMORE If Undar 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) If Under 24 Hrs. 6. Date of Birth (Month, Day, Year, 5/17/1921 Birthpleca (State or Foreign Country) **Funeral** Hours 10 M 20 F 218-05-2440 77 Yrs. Director MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f shot traumatic avent, the Medical Examiner must be notified all MD BALTIMORE WOODLAWN 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10a. Citizen of What Country? with 8530 DOGWOOD ROAD 21244 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaer or Dates: Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yas, specify Cuban, Mexicen, Puarto Ricen, atc.) 14. Rece - American Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or item 1 Navar Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes ŽXNo Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Meidan Sumame) JOHN PAGANO VIRGINIA (WELLS) 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) W. PERRY BUSH (HUSBAND) 8530 DOGWOOD ROAD WOODLAWN, MD 21244 20b. Placa of Disposition (Neme of cematary, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Steta Injury or permit. Page Department of Important: If eny injury or once. 7/14/98 WOODLAWN CEMETERY WOODLAWN, MD 4 ☐ Donetlon 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name end Addrass of Facility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD 21228 23e. Part1. Enter the diseasa, or complications that caused the deeth. Do not enter tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** /Medicai Immediata Causa (Final diseese or condition resulting in death) Breart cance 2 years Examiner Due to (or es a consequance of): Examiner Sequantially list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated evants Dua to (or as a consequence of): physician a Division of Vital Records, P.O. Box 68760, Physician/Medical thet initiated evants resulting in death) Lest Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? signed by mombosis 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Wera autopsy findings aveileble prior to completion of cause of death? 24a. Was an autopsy Completed has 1 Yas 2 10 No 1 ☐ Yas 2 ☐ No Attending Physician: director, 25. Wes cese referred to re-dical examinar? Be 26. Place of Deeth (Check only ona) Hospitel: 1 ☐ Inpatienf 2 ☐ ER/Outpatienf 3 ☐ DOA Other: 4 Nursing Home 2 1 Yes 2 5 Pasidence 6 □Other (Specify) this 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Death i or Attending Pl efter death. 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Matural 5 Panding invastigation 1 Yes 2 No 2 Accident 6 Could not be datermined To the Hospital or Atte within 24 hours efter de:
To the Funeral Directo completely filled in by th 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida 29a. Cartifian 1 Cartifying Physician: To tha best of my knowledga, daath occurred at the time, dete end place, end dua to tha causa(s) and manner as steted. Medical (Check only one) 2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and dua to the causa(s) end manner stated. 29d. Date signed (Month, Day, Year) 30. Neme end eddress of person who completed causa of daath (Item 23e) (Type, Print) 5113 MROLD 25 Main MD 320 Registrar's Signeture 31. Dete filed (Month, Dey, Year) JUL 1 4 1998 Registrar

DHMH 16 Rev 6/95



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Please Type or Print in Black Indelible Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth 13, 1998 JULY Barbara Hutchison Carson 1:50pm 4b. City, Town, or Location of Death 4a Fecility Name (If not Institution, giva straat and number) 4c. County of Death Annapolis Anne Arundel 1327 Poplar Hill Drive 5. Social Security Number 6. Sax 7. Aga (h If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 1□ M 2/□XF Months Days Yrs. July 22,1945 220-42-2078 Maryland Usual Rasidence of Decedant 10h County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 1327 Poplar Hill Drive 21401 12. Wes Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Raca - Amaricen Indian. 11. Maritel Status Black, Whita, etc. 1 ☐ Yas 2 ☒ No If Yes, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☑ Marriad 1 ☐ Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Collaga (1-4or 5+) Elamantary/Secondary (0-12) Accountant Accounting 18. Mother's Nama (First, Middla, Maiden Surnema) 17. Fathar's Nama (First, Middle, Last) Hoyt P. Hutchison Fern Jewell Barney 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) 1327 Poplar Hill Drive, Annapolis, MD 21401 a of Disposition (Nama of Date 20c. Location - City or Town, Stete Roy David Carson/husband 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, crametory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory, Inc. 7/14/98 Baltimore, MD 21. Signatura of Funeral Sarvice Licensed Dawn F. McDo 22. Nama and Addrass of Facility Cremation Society of Maryland, Inc. McDonald 299 Frederick Rd Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not anter the mode of dying, such es cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death · CARBIO-PULMONARY ARREST Immediete Ceuse (Finel disaasa or condition resulting in daath) Sequantially list conditions, if any, leading to immediate ceusa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consaquanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stata

MD

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r than "naturel", or items 23s or the Medical Examiner must be

7 is marked other traumatic event,

. Pages 1 and 2 should be file ment of Health end Mental Hy lant: If Item 27 is marked oth jury or other traumatic event

permit. Page Department of Important: If eny injury or

filed within 72 hours after death with the Marylend

Hygiane.

Baltimore, Maryland 21215-0020

60 USe

Physician/Medical þ Completed Be To funeral

physician and tha burial-transit that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, signed by the a certificate has b director, page 2 s Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Certification: C 24 hours

To the Hosp within 24 ho To the Fune completely fi 9

Registrar

Medical

24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case refarred to medical axaminer? 26. Piece of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28a. Deta of Injury (Month, Day Year) 1 Netural
2 Accidant 5 Pending 1 ☐ Yas 2 ☐ No Invastigation 6 ☐ Could not be datarmined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one)

29b. Signetura and titla of certifiar N.S. Swoonly 29c. Licansa numbar D0052965 29d. Data signed (Month, Day, Year) 07-14-1998

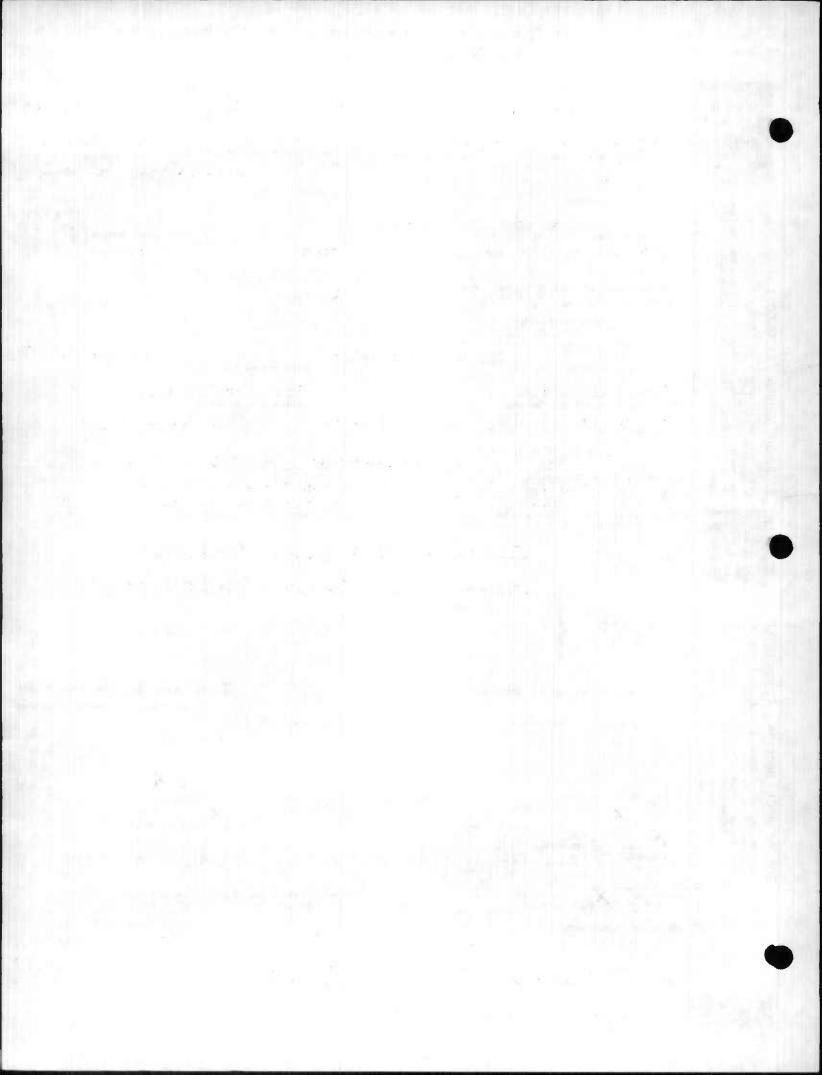
1 Yes 2 No 3 Probably 4 Unknown

30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER SATTVA SWARUP NEELAPU ROCKVILLE PIKE BETHECA MD-2085)

31. Data filed (Month, Day, Year)

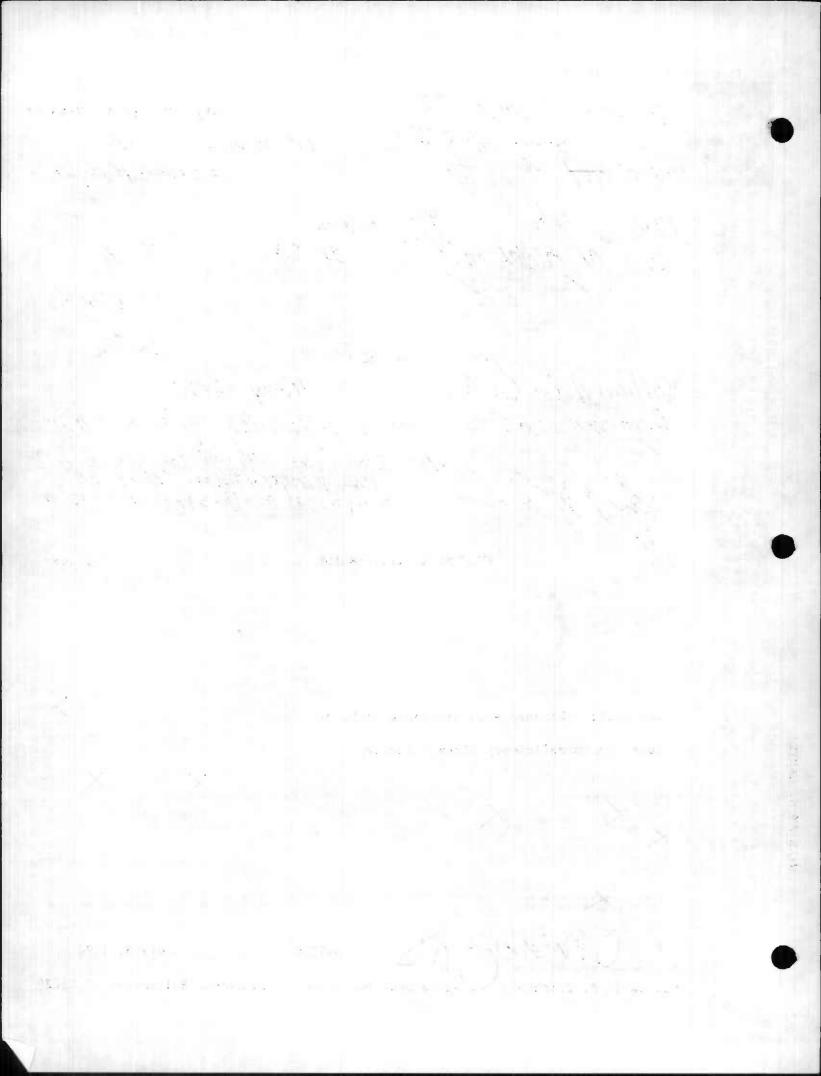
32. Registrar's Signatura

DHMH 16 Rev 6/95



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tem#5 per FH G761 7/21/98 EW	State of Maryland		te of Death		Reg. No.	211	78
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Medical William M.	(AR/ER 1)	R.		July			:40_AM
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William N. Co	RIFR SR.		Marian	1 GA	14/52/		
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2001/1 //	mes	270	PREDXITION	17/195	m17,11	10.20	24
23e. Perty/Enter the disease, or combi shock, or heart feilure. List only or	icetions that ceused the deeth. ne ceuse on each line.	Do not enter the mo	de of dying, such es cerdia	c or respiratory a	irrest,	inten	oximáte vel Between
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resulting in death)		es e consequence of					rear
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thet initiated events rasulting in death) Lest	Due to (or a	is e consequence of)				1	
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29b. Signature and title of quitilier	1/2 >	25	c. Licensa number		29d. Date signe	d (Month, Dey,	Year)
1 15/12	MAL N	1	D47380		July	9, 1998	
30. Name and eddress of person who co	ompleted source of during the liters of	23a) (Type Print)	D47300		July	-, 1770	
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Dr. David P. Fris	Derg St. Agnes	s HealthCa	ire 900 Caron	Avenue	Dallimo	ite, mu	21229
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21479 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth CHARLOTTE COLHOUER 10:15PA 4a. Facility Neme (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Deeth N/A Number 6. Sex 7. Age (in yrs. lest birthdey) Months Days JOHNS BALTIMORE
If Under 24 Hrs. 8, Dete of Birtl 5. Sociel Security Number Birthplece (Stete or Foreign Country) Days 1 M 2 F Hours 84 216-03-2707 April 3,1914 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Dundalk Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21222 United States 8267 Kavanagh Road 12. Was Decedent Ever In U,S. Armed Forces? 11. Maritel Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 2 No Specify: Specify. White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) 8 Years College (1-4or 5+) Sewing Factory Seamstress 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Charlotte Ruth Pearce Charles A. Sturm 19a. Informent's Neme/Reletionship (Type, Print) Daughter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8267 Kavanagh Road Dundalk, Maryland Ms. Charlotte Robinette 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 M Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery 7/16/1998 Baltimore, Maryland 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dunalk, Inc. 7922 Wise Ave. Dundalk Maryland 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Beh Immediate Cause (Final 24 Hours disease or condition resulting in deeth) Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PARKINSON'S DISPASE 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? FND STAGE DEMENTIA DIABETES MELLITUS 1 Yes 2 No 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) exeminer?
1 Yes 2 No

27. Manner of Deeth
1 Neturel
2 Accident Hospitat: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homloide

Box 68760, P.O. of Vital Records, Division

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Certification:

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29a. Certifier (Check only one)

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filed within 72 hours after

Pagas 1 and 2 should be

21215-0020

Maryland

Baltimore,

State Registrar ESIDENT

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

97008 HYSICIAN

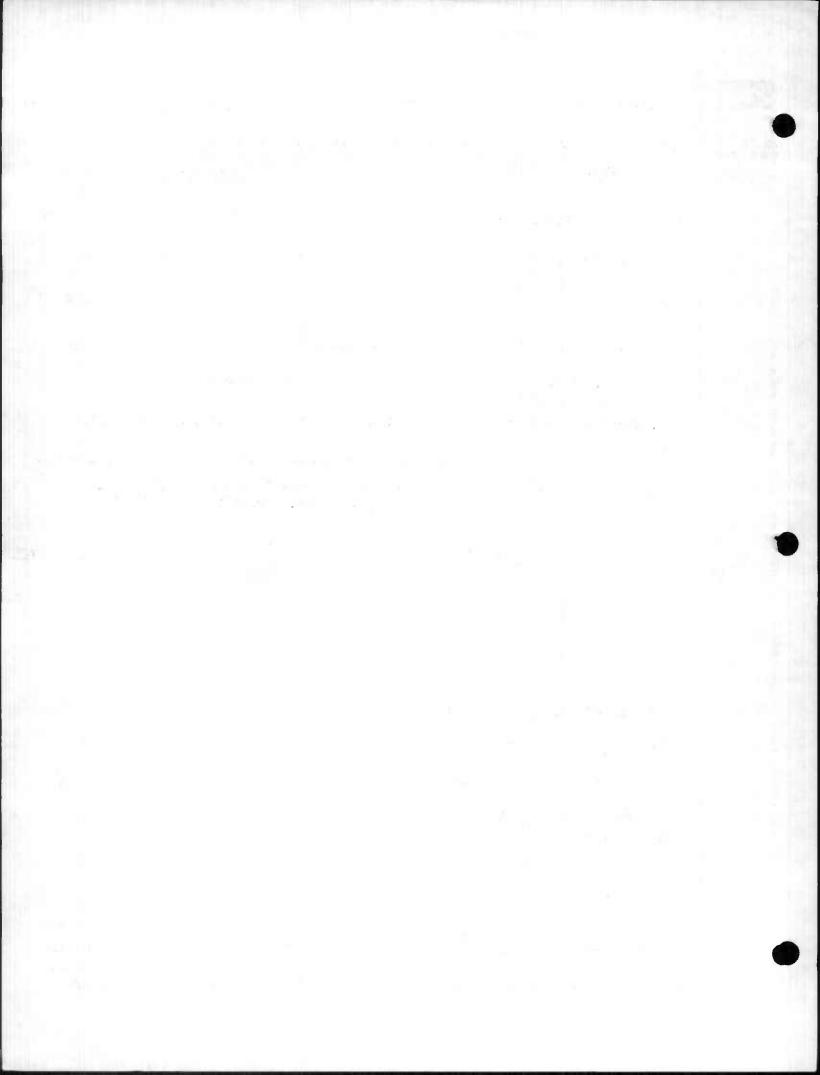
30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) PATIENCE AGBORBESONG 4940

EASTERN AVENUE, BALTIMORE MARYLAND

31. Dete filed (Month, Pay, Year)

29b. Signeture end title of certifier

32) Registras's Signether



State of Maryland / Department of Health and Mental Hygiene

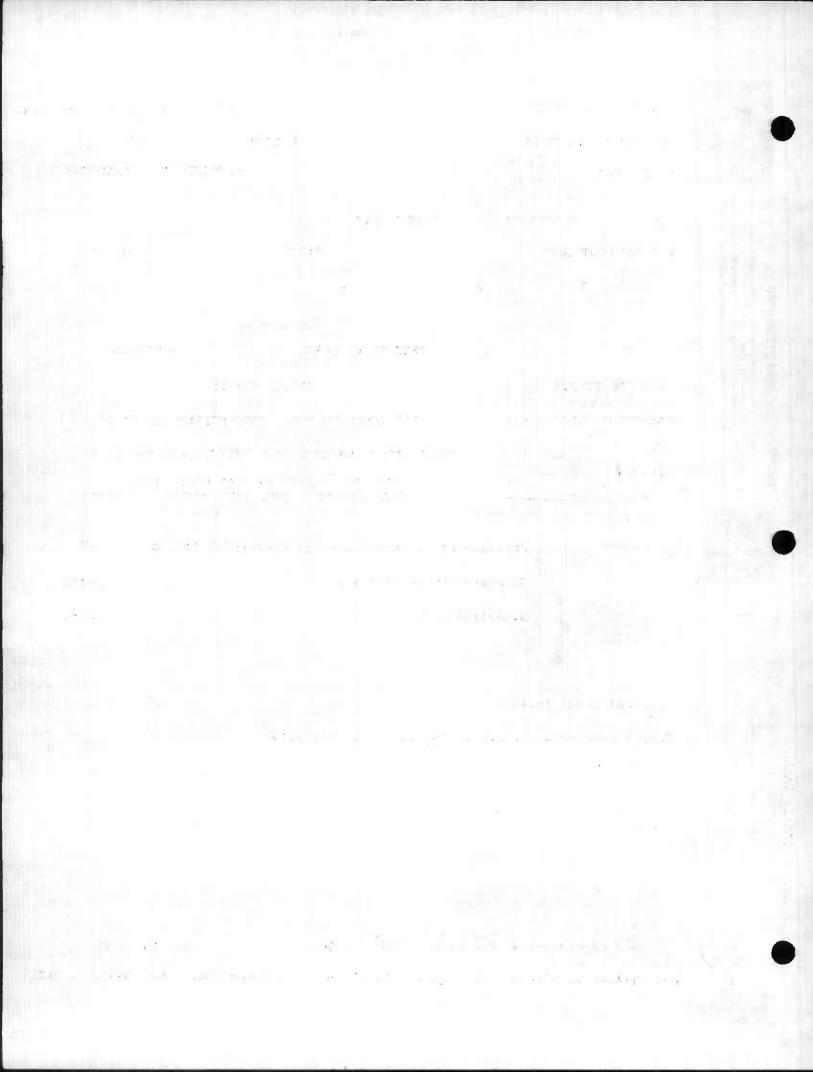
Certificate of Death 1 Decedent's Neme (First, Middle Last) 2. Dete of Deeth 3. Time of Deeth Month Day Year **Physician** MARIE BIGGS CARLL 4b. City, Town, or Location of Death 1998 0100 a.m. /Medical 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner ST. AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖔 F Months Deys Hours 74 Yrs. 02/05/1924 KENTUCKY Director 215-32-0862 Usuel Residence of Decedent the Maryland 10d. fnside City Limits 10e. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show trsumatic event, the Medical Essentian must be notified at 1 Yes 2 No Director BALTIMORE MD CATONSVILLE 10e. Street end Number 10f. Zin Code 10a. Citizen of Whet Country? with 103 WOODWIND ROAD 21228 U.S.A. death Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours aftar c Department of Health and Mental Hygiane. Important: if item 27 is marked other than "natural, or item any injury or other traumatic event, the Wedgell Error in natural. 1 ☐ Yes 2X No 1 Never Married 2 Merried Specify: WHITE Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 3 REGISTERED NURSE HOSPITAL 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) LEANDER SEXTON EASTER SEXTON 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) THEODORE CARLL/HUSBAND 103 WOODWIND ROAD CATONSVILLE, MD 21228 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete cemetery, crematory or other piece) 1 X Burial 2 ☐ Cremation 3 ☐ Removet from State MEADOWRIDGE MEMORIAL PARK 7/16/98 BALTIMORE, MD 5 Other (Specify) Bervice Licenses 22. Neme end Address of Fecility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, eart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medicai mmediete Ceuse (Final Possible early subendocardial myocardial infarct 1-2 days diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner Coronary atherosclerosis years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of). The law requires that the daath cartificata berey Hyperlipidemia vears physician Box 68760 Physician/Medical Due to (or es e consequence of): signed by the a Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. Terminal renal failure 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy Completed Status post coronary artery bypass and aortic valve peen has replacement 1 Yes 2 No 1 Yes 2 No certificate or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 : Aftar this a funaral die 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 1 Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigetion To the Rospital or Attandi within 24 hours after death To the Funeral Director; A completely filled in by the fi 2 Accident tha 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, Stete) in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) end manner es stated.

2 Madical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and plece, end due to the cause(s) end menner stated. edical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end tifle of certifier 29c. License number Decken InD July 13, 1998 30. Name and eddress of person who completed ceuse of death (Item 23e) (Type, Print) Dr. William J. Hicken - St. Agnes HealthCare - 900 Caton Ave. - Baltimor, MD. 21229 32. Registar's Signature
Stulia Davidson Randall 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

Registrar

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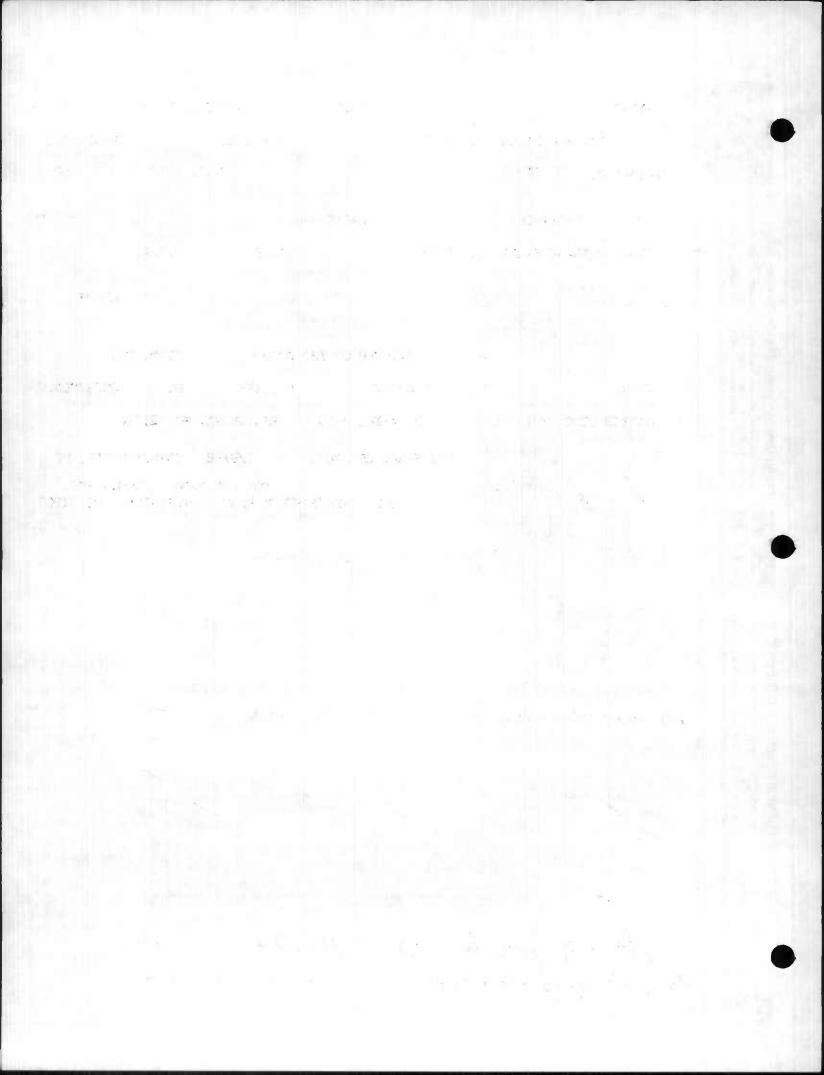
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** JULY 8, STONEY CHECKET 1998 5:30 AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner 7202 ROCKLAND HILLS DR. #303 BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC.4, 1919 Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Hours Min 1 € 1 2 F Yrs. 78 MD Director 071-16-1283 Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ? is marked other than "natural", or items 23s or 28s-f show traumatic event, the Mod call Examiner must be notified at 1 Yes 2 No Directo MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 23a r 7202 ROCKLAND HILLS DR. #303 21209 U.S.A. Funeral death 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite 1 Yes 200 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 Merried 1 Yes 2 No Specify: Specify: WHITE Š 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4 CHAIRMAN OF THE BOARD FURNITURE 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) HENRY CHECKET PAULINE GREENBLATT M. 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) JANICE CHECKET (WIFE) 9 HAMILL ROAD BALTIMORE, MD 21210 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 6 1 Buriel 2 Cremetion 3 Removel from Stete 7/9/98 OWINGS MILLS, MD HAR SINAI CEMETERY any injury o 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In death) Examiner Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of) and P.O. Box 68760 law requires that the death certificate be-Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? the 1 | Yes 2 No 3 | Probably 4 | Unknown 6 teriosclero to Cordiovascular discus Division of Vital Records, þ 24b. Were autopsy findings evaileble prior to 24a. Was an autopsy performed? Completed need completion of ceuse of deeth? has The 1 Yes 2 No certificate 1 □Yes 2 □ No Physician: 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidenca 6 Other (Specify) 2 1□ Yes 2☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28e. Dete of Injury (Month, Dev Year) Certification: or Attending 1 Neturel 5 Pending investigation s after death.

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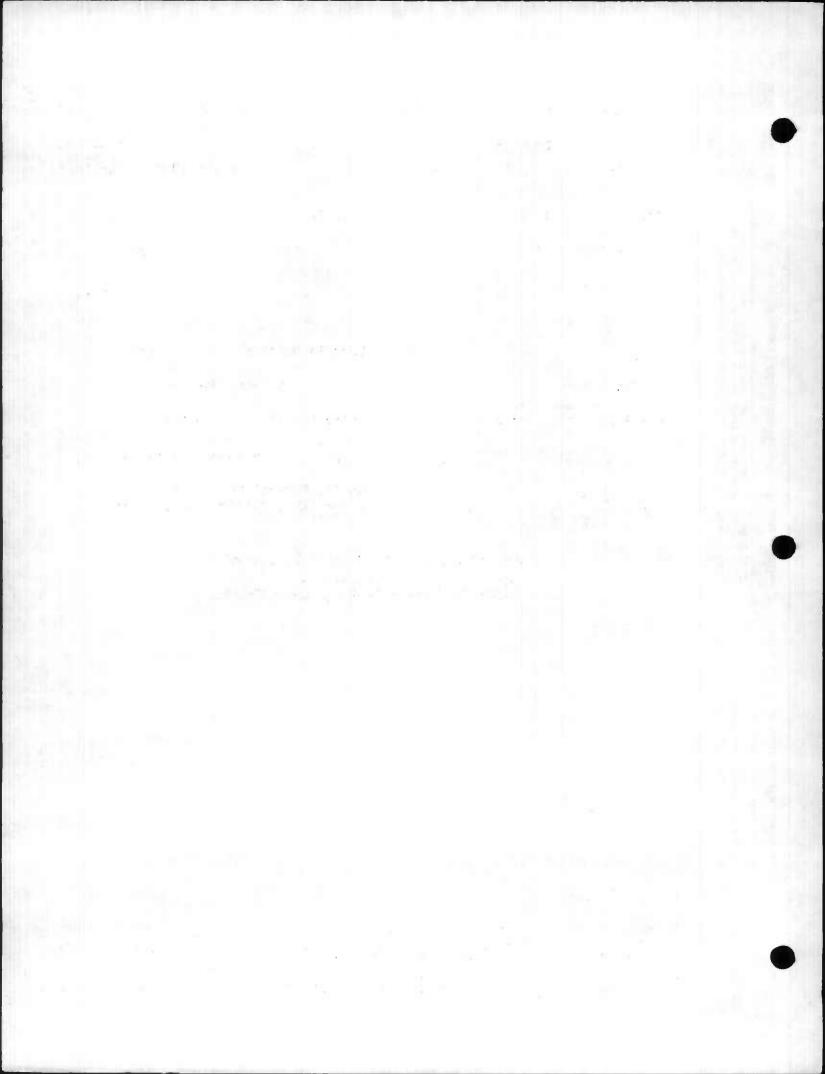
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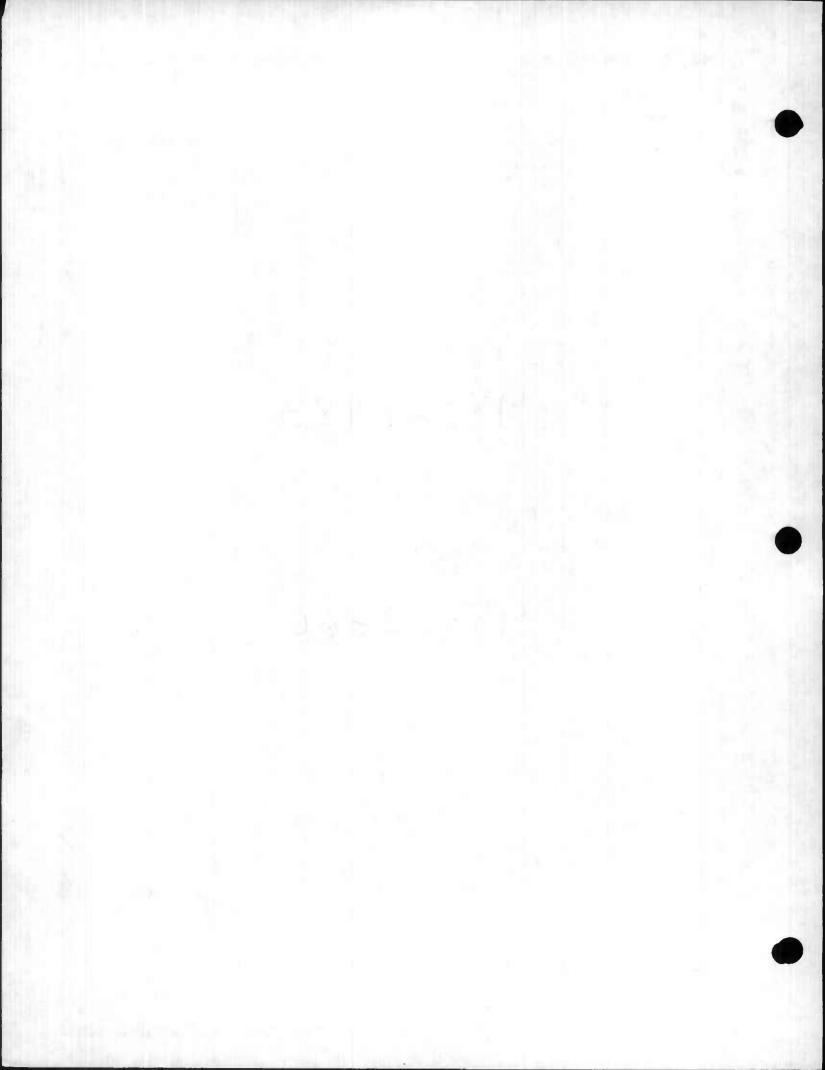


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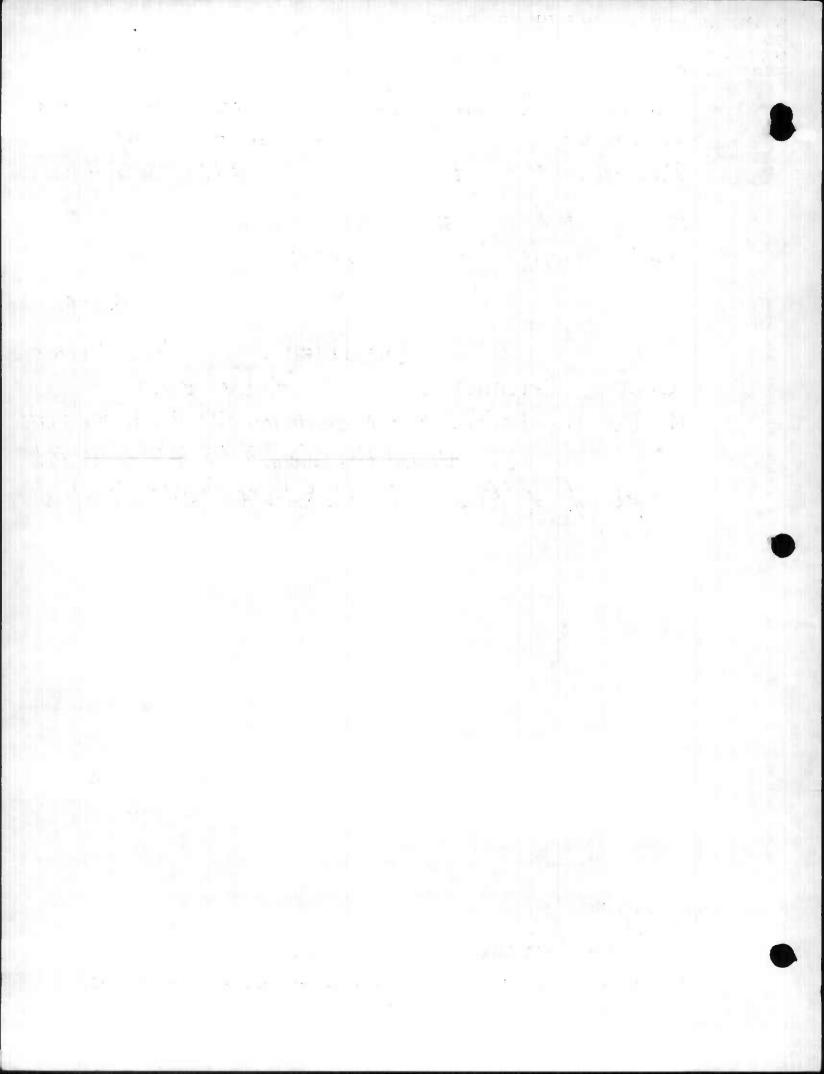
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	-		1. Decedent'e Neme		> :	T			2. Date of Dea Month	th	Yaar 3. 1	Time of Death
	Physicia /Medic Examin	al	George 4a Fecility Name (if	de institution, giva s	DOWNIN freet and number)	g Jr.	4b. Cit	ty, Town, or L	JULY 0'	7, 1998	2	034PM
	Examini	CI	MD GENERA				BAI	TIMORE	CITY	/	V/A	
	Funeral Director		5. Social Security Nu. 212-56-1 Usual Residence of D	mber 6. Sex 134	M 2□ F 7. Age (In yrs.	/ Yrs. If United Month		Jndar 24 Hrs. ours Min.	8. Date of Birth Month, Day	7,1950	South	(Stele or Foreign
	death with the Maryland rms 23e or 28e-f show r must be notified at	ctor	Maryland	10b. County	10c. Ci	altimo	re					nside City Limits ☐Yas 2☐ No
	23a or 24	Funeral Director	10e. Street and Number 927	Aravl	e Ave.	10f.	Zip Code 2120	/	1	0g. Citizen of V	What Country?	
	items instrum	Juer	11. Maritel Stetus	7771	Was Decedent Ever in U Armed Forcas?	J,S. 13. Was De	cedant of Hispen pecify Cuban, Me	olc Orlgin? (Spexican, Puerto	ecify Yas or No- Rican, atc.)		a - Amarican In- k, White, etc.	dian,
21215-0020	8 6	by	1 Never Marrier 3 □ Widowed 4		1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:			ecify:		Specify	blac	K
15-		Completed		 Decedent's Educ y only highest grade 			suel Occupation work done during use retired)	most of work	ing	16b. Kind of Bu	isiness/Industry	1
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Maryland	should be filed wit and Mental Hygiene a marked other tha umatic event, the	To Be C	17. Father's Name (F	First, Middle, Last)	owning	Sr	18.	Mother's Nam	e (First, Middle,	Maiden Sumem	a)	
ary	2 should and Men is marke sumatic	-	19a. Informent's Nah	ne/Relationship (Typ	e. Print) (COUSIN)	19b. Mailing Addre	ess (Street end N	Vumber or Rui	ral Route Numbe	r, City or Town,	Stete, Zip Code	e)
altimore, M	Health item 27 other tr			Cramation 3 Ra		Place of Disposition (I cemetery, crematory)	Bent Warme of or other piece MT	alou ./ZION	St. 7/16/98	Balt 20c. Location - Lanso	City or Town, S	. 21216 Stata M.J
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ä	Ded		· Char	onl	f. Kun	Jose	Ph. ti	Rys	5 -44	reral	Hom	1211
			23a. Part Enter the	ase, or complic	ations thet caused the dee e cause on each line.	th. Do not enter the m	node of dying, su	ch as cardiac	or respiratory and	est,	App	oroximate rval Between
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0,	an and inal-transit	Examiner	Sequentially list conditions, leeding to immicause. Enter Under	nediate lying	Due to (or as a consequence	of):					
Box 68760,	The law requires that the death certificate be exate has been signed by the attending physician spage 2 should be detached for use as the burial	Physician/Medical	Ceuse (Disease or In thet initiated events resulting in death) La		Due to (d	or as a consequence o	():					
. Bo	death certification of for use as	iclan	Pert II. Other signific	ant conditions cont	ributing to death but not res	sulting in the underlyin	g cause given In	Part I.	23b. Dld t	obacco use co	ntribute to the	causa of death?
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Division of Vital Records,	aw requiras is been sigi 2 should by	Completed b							24e. Was a perfor		availebi	utopsy tindings le prior to tion of cause 1?
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/ita	slan: artifica actor,	Be	25. Was case referre					Place of Dee	th (Check only o	ne)		
of	Physician: rthis cartific ral director,	To	1 ☐ Yes 2 ☐ N 27. Menner of Death	lo Ho		1		☐ Nursing He	ome 5 Resid			
O	ding I h. After funer	tlon	1 Neturel 2 Accident	5 Pending Investigation	28e. Dete of Injury (Month, Dey Year) 7-7-98	28b. Time of Injury UNKNOWN M	28c. Injury et Work? 1 ☐ Yes	2 🗓 No	UNKI		100	
)ivisi	or Attending star death. Director: After In by the fune	ertifica	3 Suicide 4 Homicide	6 X Could not be determined		nome, ferm, straet, fac			28f. Location (5 City or Tow		ARGYLE A	ate Number, AVE .
	To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this cardificate has been si completely filled in by the funeral director, page 2 should	edical Certification:	(Check unit) 2		cian: To the best of my kno ar: On the basis of examine	owledge, death occurr			end due to the	ause(s) end me	enner es stated	
	ithin 2	Med	one) 29b. Signature and ti	tle of certifier	end menner stated.		29c. Licansa nun	nber		29d. Data signe	d (Month, Dav.	Year)
	F ≱ F 8		1/14	In fort	0110							-74
			30. Neme end eddres	ss of person who con	npleted cause of deeth (Ite	m 23a) (Type, Print)	O.C.M	.E.		JULY 08	, 1998	
	7		JUALON 31. Date filed (Month	n lucke	ino	111 Per		t, Bal	timore,	Marylar	d 2120	1
	Sta Registra			JUL 1 4 199	8 Marian	avidron Brando	00_					



CHARLES DYE

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or frama 23a or 28a-f ahow traumatic event, the Medical Examinat mast be notified at

other

injury or

		State	of Marylai		rtment tificate				Mental Hy	giene Reg. No.	3 (21485
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5. Social Security 1 327–26–82	211	6. Sex 11 M 2 □ F	7. Age (In yrs	last birthday) 62Yrs.	If Under Months	1 Year Days	If Undar Hours	24 Hrs. Min.	8. Dala of Bir (Month, De July 7,	y, Year)	_ Co	hplaca (State or Foraign buntry) LINOIS
Usual Residanca d 10a. Stata MD	10b. County N/A			ty, Town or Lo								10d. Insida City Limits 1 ∰Yas 2 □ No
10e. Street and Nu 3501 St		Street, #	‡846		10f. Zip		1218			10g. Citizen of Unite		
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Elamentary/Sec	ondary (0-12)	Collaga	(1-4or 5+) 4	Civil	Engi					Federa	1 Gov	vernment
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19a. Informani's N	eme/Relations Dye/ W								re/Routa Numb , Balti			
	. 37	3 □Ramoval from	Stata	Place of Dispo camatary, crar een Mou	netory or o	ther pla		7	Data 7-14-98	20c. Location		
21. Signature of F	Service XX	Human	m			- S	tephe	ń D.	Lohrma			, MD 21286
23a. Part1. Enfer shock, or had	the diseasa, or art failura. List	complications that only ona causa on	causad tha das aach lina.									Approximate Intarval Between Onsel and Death

Physician /Medical Examiner

> Examiner Physician/Medical þ Completed Be 0 Certification:

attending physician and for use as the bunal-transit The law requires that the death certificate be executed signed by the a peen 24 hours after death.

Funeral Director: After this certificate has page 2 Hospital or Attending Physician: director. funeral the completely filled in by

Division of Vital Records, P.O. Box 68760,

within 2 to

To the

Medical

(Check only one)

31. Data filad (Month, Dey, Yaer)
JUL 14 1998

23a. Part1. Enfer the disc shock, or haart failu Immedieta Cause (Final disaasa or condition resulting in daath) Dua to (or as a consaquance ol): Sequantielly list conditions, if any, laeding to immadiata causa. Enter Underlying Causa (Disaasa or Injury that Initieled avants rasulting in death) Last Dua to (or as a consequence of): Due to (or as a consaguanca ol): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably (Unknown Diabetes Mellitus 24e. Wes en eutopsy INSPECTION

24b. Were autopsy lindings aveilable prior to complation of cause of daath? 1 Yas XXNo 1 ☐ Yas 2 ☐ No 25. Was casa ralarred to medical examinar? 26. Place of Death (Check only ona) Othar: 4☐ Nursing Homa 5☐ Residenca 6☐ Othar (Specify) 1XX es 2□ No 1 ☐ Inpatiant XXER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 27. Menner of Deeth 28b. Tima of 1 X Vetural 5 Pending 1 Yas 2 No Invastigation 2 Accident 6 Could not be datamined 28a. Placa of Injury - Al home, ferm, streat, factory, office building, etc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, Stata) 3 Suicida 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the causa(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Cartifier

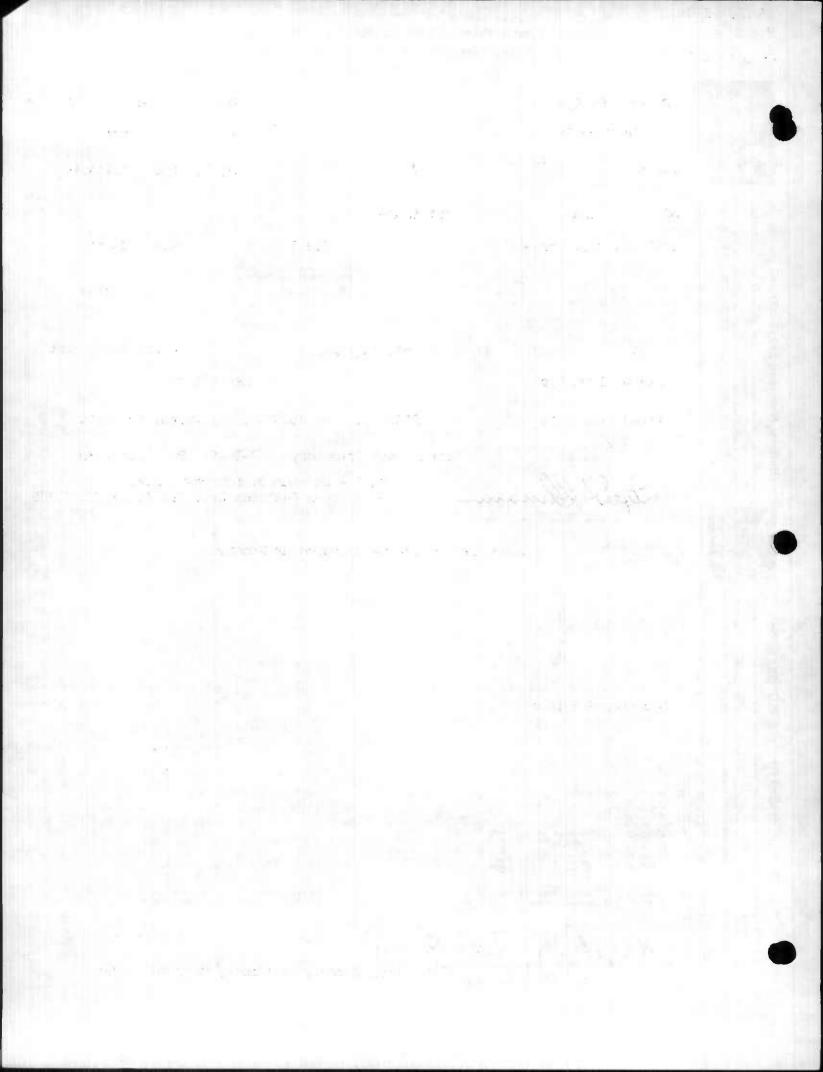
29b. Signature and little of certifia

29c. Licensa number O.C.M.E 29d. Dete signed (Month, Dey, Year) JULY 11, 1998

30. Nema and address of person who complated cause of daeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 phyn Radyntz

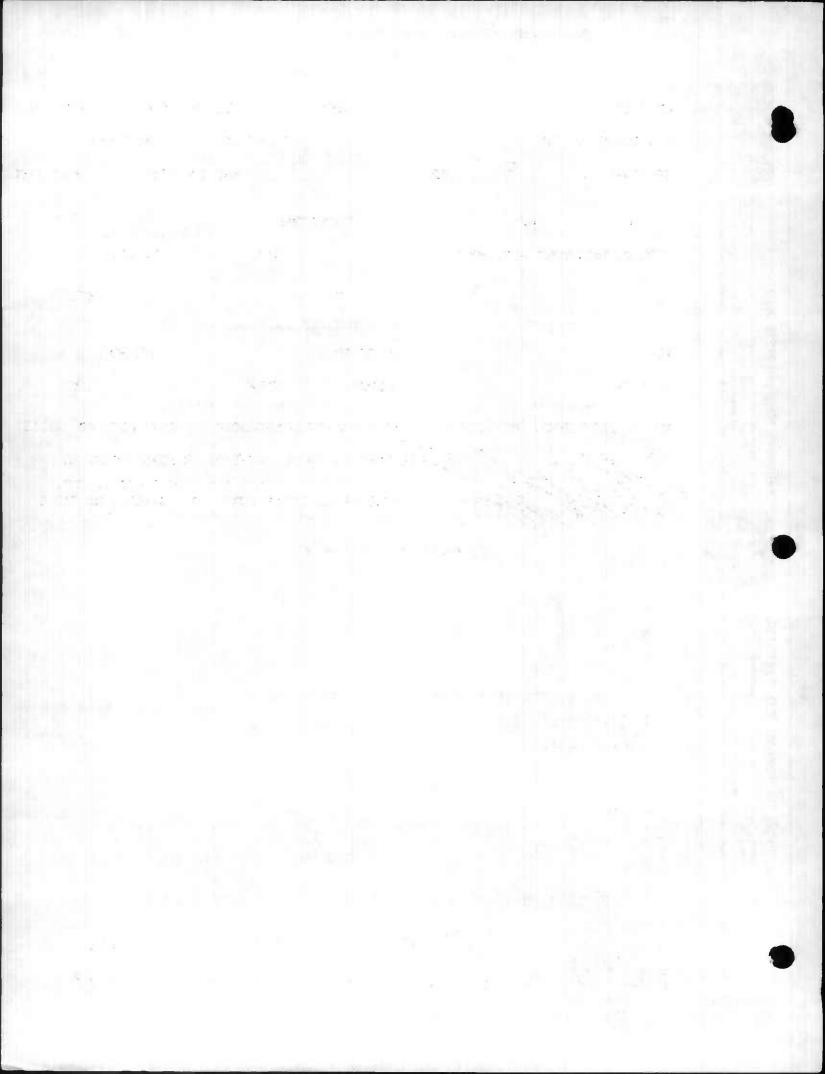
State Registrar Pagistrar's Signatura Devidson Bandalle



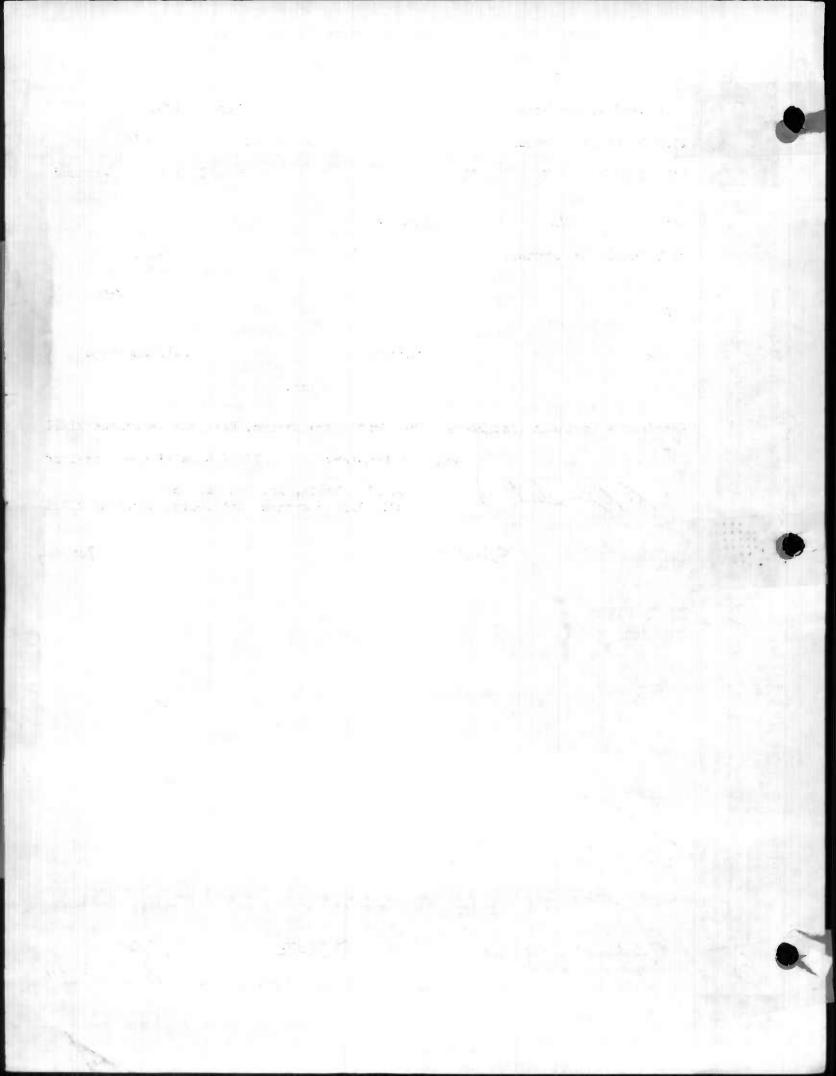
State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of	Death	Re	g. No.) (1486	
H., H.,	1. Decedent's Name (First, Middle, Last	")				2. Date of Daatt				
Physician /Medical	MILDRED			DIC	K	JULY 8,		1021	2:00 AM	
Examiner	4a Facility Nama (If not institution, give	street and number)			4b. City, Town, or Lo	ocation of Death	Day Vear Z 8, 1998 Death 4c. Country of Death BALTIMORE S Birth Placa (State Country) 10, 1916 10d. inside Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry OWN HOME iddle, Maiden Surname) LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVE LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LEVY LE			
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show stat	Usual Residence of Decedent 10a. Stata 10b. County		10c. City, Town or	r Location				100	d. Inside City Limits	
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or name Examiner m by Funer	11. Marital Status 1 Nevar Marriad 2 Married 3 🌣 Widowad 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🕍 N If Yes, Give Year or Dates:	Armed Forces? If Yes, specify Cuban, Maxican, Puêrtô Rican, atc.) Black, W 1 ☐ Yes 2 🛣 No If Yes, Specify: Specify: Specify:					k, White, et	tc.	
"natural".	15. Decedent's Edu (Specify only highest grad	ucation le completed)	16a. De	ecedent's Usual Occi	upation e during most of work	ing	16b. Kind of Bu	siness/Indu	ıstry	
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vent, the M vent, the M Se Comp	12			HOUSEWIFE						
\$ 0 m	17. Father's Name (First, Middle, Last)						faiden Sumam			
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Eng.	19a. Informant's Name/Relationship (T)	ype, Print)	19b. M	alling Address (Stree	et and Number or Run	al Route Number,	City or Town,	State, Zip C	Code)	
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Departr Importa any inju	21. Signature of European Sociolo Licono	2		22. Name and Add	ress of Facility	L LEVINS	ON & B	ROS.	INC.	
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sician edicai	Immediate Cause (Final disease or condition			ic Cano					Onset and Death	
kaminer	resulting in death)	a	Due to (or as a consequence of):							
an end inie transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or as a con	sequenca of):						
ling physicie se es the bur Medical	resulting in death) Last	d	Due to (or as a consequence of):							
ed by the attendir deteched for use r Physician/R	Part ff. Other signiffcant conditions con		ut not rasulting in th	ne underlying causa	given in Part i.	23b. Did to	bacco use co	ntributa to	the cause of death?	
ed by the deteched	111 -						1			
sele has been signed by the attendi page 2 should be deteched for use Completed by Physician/	Derression.					24a. Was a perform	n autopsy ned?	com	re autopsy findings llable prior to appletion of cause eath?	
page 2						1 □ Ye	s 2/13 No	10	Yes 2□ No	
certificate rector, pag	25. Was case referred to medical				26 Place of Dee	th (Check only on	•			
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6 =	27. Magner of Death	28a. Date of Injur	y 28b. Tim	e of 28c. fn	4)ZTHUISING H	28d. Describe ho				
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within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral Medical Certification:			examination and/o		time, date and place, opinion, death occur					
ompl ompl	201 21 1 100	1	1.	29c. Lica	nse number	2	9d. Date signe	d (Month, D	Day, Year)	
- 0	29b. Signature and partifier	/1	10		20270		21	010	C	
	29b. Signature and the or cartifier	// ^	11)	D	20319		//	1 / 71		
5	30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Ty	pe. Print), Con	10339 .+ Rd; B	altimore	, 100	21	ros	

DHMH 16 Rav 6/95



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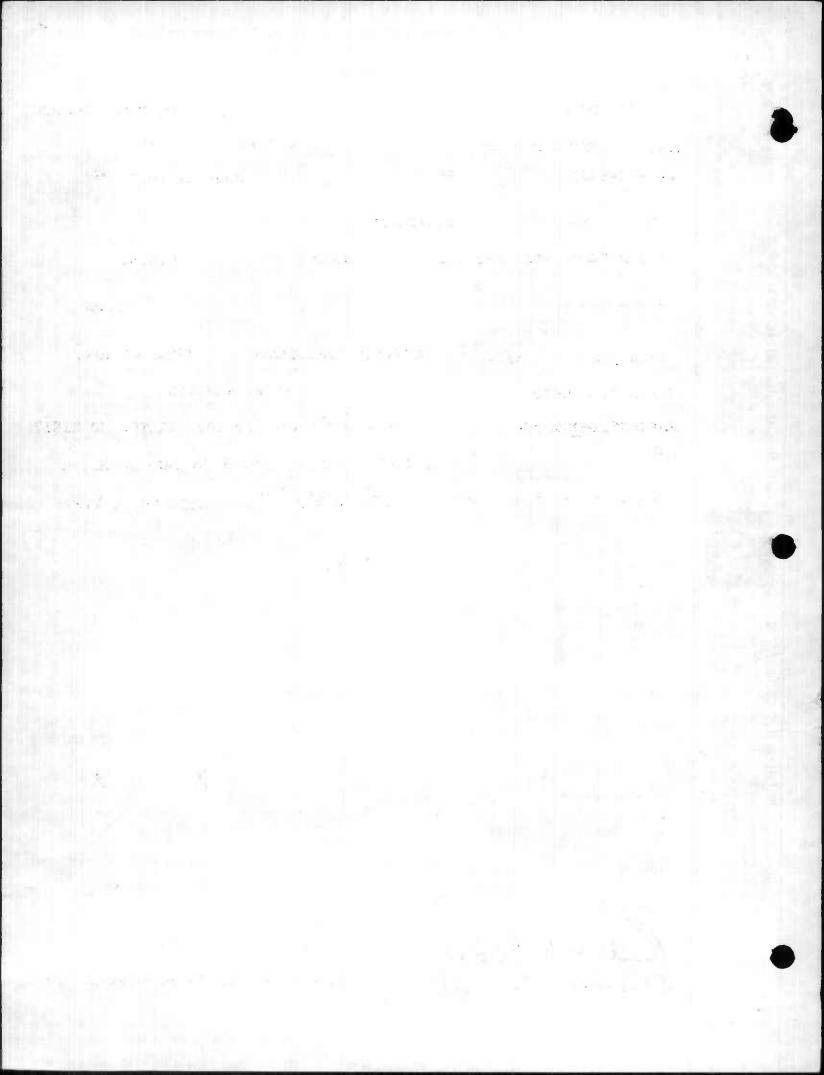
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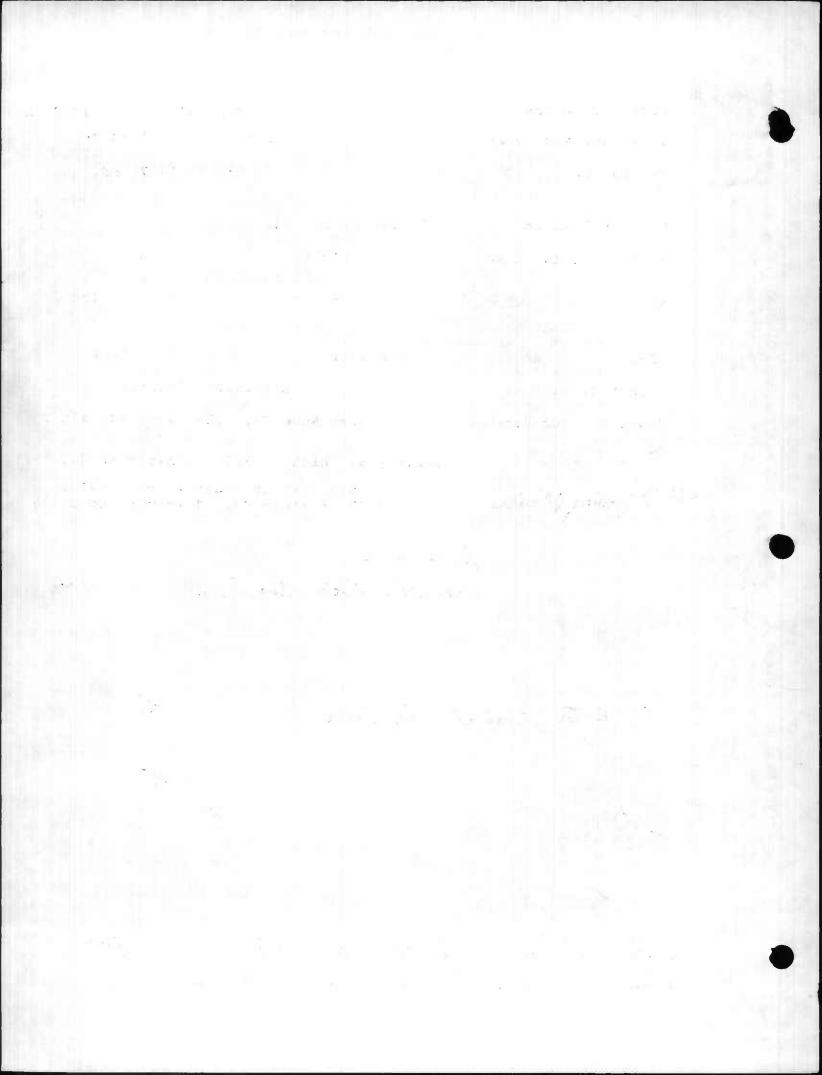
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by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorcad	Armed Force	s? No		Yes, speci		Specify:	Specify Yes or No into Rican, etc.)	Bla Specif	ck, White, etc.	
	15. Decedent's (Specify only highest	Education		16a. Deced	lent's Usual	Occup	pation	ndrina	16b. Kind of B	susiness/Industr	
Completed	Elementery/Secondary (0-12)	College (1-4	College (1-4or 5+)		(Give kind of work done during most of working life. DO NOT use retired) CTIVITY ASSISTANCE						
S	12th grade 17. Father's Name (First, Middle, L	N/A	A1/ A1		TTY .	ASSISTANCE 18. Mother's Neme (First, Mi			NURSING HOME Middle, Maiden Surname)		
To Be C		JAMES F. JOHNSON						E. RAND			
To	19a. Informant's Name/Relationshi			19b. Mailir	g Address	Street		Rural Route Numb		, State, Zip Cod	le)
	RUTH SMITH MC	THER	l and	1519	MADI	SO	N AVE	PT 102		O, MD	
	20a. Method of Disposition 1X Buriel 2 Cremation 3	B □Removal from Sta		Pleca of Dispo cemetery, crem	sition (Nem- netory or of	er pla	ce)	Date	20c. Location	- City or Town,	Stete
	4 Donetion 5 Other (Spe		ľ	MT ZIO				7/13/98	BALTI	MORE,	MD
poce	21. Signature of Funeral Service Li	Cerisee		22. Name end Address of Facility MARCH F/H WEST							
	23a. Par1. Enter the disease, or c shock, or heert failure. List or	omplications that ceu	sed the dea	4	1300	WAI	BASH AV	E. BAL	TIMORE errest,	App	215 proximate prval Between
an cal ner	Immediate Cause (Final disease or condition resulting in death)	a	Due to (IVER (or as a conseq	uence of):					One	set and Deeth
mine	30	b									
al Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events	C	Due to (or as a consequence of):								
ician/Medical	resulting in death) Last	d	Due to (or as a consequence of):								
C	Part II. Other significant condition	s contributing to deat	h but not re	suiting in the u	ndedvina ca	ise oi	ven in Pert I	23b. Dia	tobacco use co	ontribute to the	cause of death?
by Physician/M	Part II. Other significant condition	s contributing to deat	TI DUCTION O	suting in the di	idenying ca	erlying cause given in Pert I.			3b. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
Completed								24a. Wa	s an autopsy ormed?	availeb	utopsy findings le prior to tion of ceuse h?
Com								1/20	Yes 2□No	1 Ye	s 2 No
B	25. Was case referred to medical examiner?	Hospital:				Ott	200:	eath (Check only			
	11☑ Yes 2☐ No 27. Manner of Death	1 🗆 Inp		XER/Outpatier 28b. Time of			4 U Nursing	Home 5 ☐ Res	CANAL PROPERTY OF		
edical Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion of be		Injury	М	1 🗆	ury at onk? ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28d. Location (Street end Number or Rurel Route I			ute Number.	
Medical Certificati	4 Homicide determin	building	, etc. (Spec	ify)				City or To	own, Stete)		
edica		Physician: To the be caminer: On the basi end menner	s of examin								
Σ	296. Signiful and title of cartifier	10			29c.	29c. License number			29d. Date signed (Month, Dey, Year) JULY 8, 1998		
	Jain	tortes	M			0.	C.M.E.		JULY 0,	1330	
	30. Name end eddress of person w	ho completed cause	of deeth (Ite	m 23e) (Type,		Don	n Street	t, Baltin	more Ma	arvland	21201
1	J. GIYEUU -		1111	,	1.1.1.	T CI	" Derec	C) LICILILIE	III		



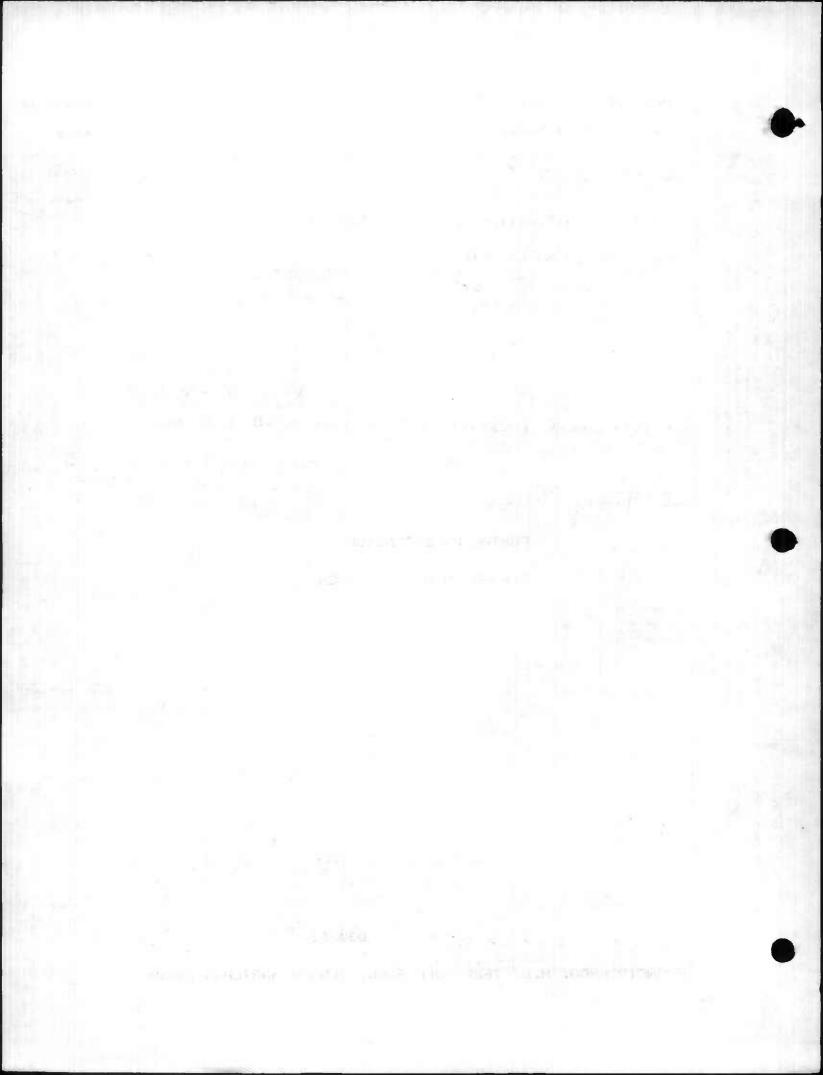
State of Maryland / Department of Health and Mental Hygiene

				Tylana / L	Certificat				Reg. No.	6	1489	
Physician		1. Decedent's Name (First, Middle, Last)		2. Date of D Month		Death Day Yeer		3. Time of Deeth				
/Med		Grace G. DeOm			July :	11. 199		1030 AM				
Exam		4a Facility Neme (If not Institution, give s			own, or Location of Death 4c. County of Death							
		2912 Emerald	Road		i Klade	r 1 Year	Baltim					
Funera Directo		5. Social Security Number 6. Sex 2 1 7 0 5 6 9 0 3	M 2 K	(In yrs. last birt	Yrs. Months		If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da May 19	y. Year) 1917	9. Birthpl Count Md	ace (State or Foreig ry)	
B # 18		10a. State 10b. County 10c. City, Town or Location								10d. Insid		
with the Maryland a or 28a-f show be notified at	t or 28a-f sh be notified.	Md Baltimor		Ra	ltimor	e C	o Md.				1 ☐ Yes 2 ☑ No	
th the or 28		10e. Street and Number				p Code			10g. Citizen of W	hat Count	ry?	
23e vi	la la	2912 Emerald	Road			212	3 4		USA			
020 urs atter dea al', or items Examiner m	ould be filed within 72 hours Mental Hygione. arked other than "natural", witic event, the Medical Exa To Be Completed by	11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dales:				dispanto Origin? (S) an, Mexican, Puerti Specify:	pecify Yes or No o Rican, etc.)		- America k, White, e White	etc.	
72 h		15. Decedent's Educ (Specify only highest grade	etion completed) College (1-4or 5-	16a.	Decedent's Usu (Give kind of wo life. DO NOT u	al Occup ork done ise retire	pation during most of world)	king	16b. Kind of Bu	siness/Ind	ustry	
21 d with		12th N	er				Home	2				
DG Selfig Vent		17. Father's Name (First, Middle, Last)					18. Mother's Nen	ne (First, Middle,	Maiden Sumame	9)		
yla Ment		Robert H. Chap						abeth	Barret			
S 2 2 2 2		19a. Informant's Name/Relationship (Typ. James H. DeOms		19b.			and Number or Ru Echo Ct					
	9	20a. Method of Disposition	7 8 0 11	20b. Place of	Disposition (Na	me of		Date	20c. Location - (
Baltimore, semit. Pages 1 a Separtment of Nea mportant: if Item iny Injury or othe		1 Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State		ens of			7/14	Baltim	ore	Co	
altin		21. Signature of Funeral Service License	9	Gard	22. Name a	nd Addre	ss of Facility					
m sale	Department of Department of Important: If I any Injury or acce.	The work will	000				Miller					
11.150		23e. Pert1. Enter the disease, or complice shock, or heart failure. List only one	ations that ceused	he death. Do n	7 5 2 7 not enter the mod	H de of dyir	arford ng, such as cerdiac	Rd., B or respiratory a	altimor rrest,	e Mo	Approximate	
l Physiciar		snock, or near failure. List only on	e ceuse on each line	э.							Interval Between Onset and Death	
/Medica Examine	_	Immediate Ceuse (Finel disease or condition	(i)	2 eur	onic							
LAGITITIE		resulting in death) a.		Due to (or as a c	consequence of)		~					
pe led	min.	b	14	CHASTA	tic C		n Care	none		- 1	14%	
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riffica ng ph		resulting In death) Last		,						i		
Both cert ettendin for use	Physician/M	d.										
the ed	/sic	Part II. Other significant conditions cont	ributing to death but	not resulting in	the underlying	ceuse giv	ven in Part I.	23b, Dld	tobacco use con	tribute to	the cause of death	
is, P.O. BOX es that the death cer igned by the ettendin be deteched for use	by Phy	Eato	Lanber	t 5	emde	me	,	10	Yee 2000	3 Prob	ebly 4 Unknow	
Ord requir mould	Completed							24a. Was parto	an autopsy rmed?	ava	re autopsy findings illable prior to apletion of ceuse leeth?	
VITAL HEC SICIEN: The law s certificate hes b director, page 2 s	E O							10	Yes 20 No	1 🗆	Yes 2□ No	
Attifica ctor,	Be	25. Wes cese referred to medical examiner?					26. Plece of Dee	eth (Check only o	one)			
OIVISION OF VITAI or Attending Physicien: T sher death. Director: After this centificat I in by the funeral director, p.	2	1 □ Yes 20 No	spital: 1 Inpatien				4 LI Nursing H		dence 6 Othe)	
After funer	lon	27. Menner of Death 1 Neturel 5 Pending	28a. Dete of Injury (Month, Day		ime of njury M	28c. Injui Woi	ry et rk? Yes 2 □ No	28d. Describe	how injury occurr	ed .		
DIVISIO	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	v - At home fai			163 2 110	28f. Location (Street and Number	er or Rura	l Route Number.	
Div.	erti	4 ☐ Homicide determined	building, etc.	(Specify)	, 5.1.551, 12515.	y, office 28f. Location (Street and Number or Rural Route No City or Town, State)						
LIVISION OF VITAL HO To the Hospital or Attending Physicien: The is within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	clan: To the best of er: On the basis of and manner stat	examination end	, death occurred Lor investigetion	at the tir	me, date and place opinion, death occu	, and due to the trred at the time,	cause(s) end ma dete and place, a	nner as st and due to	ated. the ceuse(s)	
ro the	M	29b. Signature and title of certifier	1	-	29	c. Licens	License number 29d. Date			(Month, I	Day, Year)	
		Na Ta	1 2	h 15569 71			1/98	~				
10		30. Neme and address of person who cor	pleted cause of de	ath (Item 23e) (Type, Print)	Ud	55-1	(1.	1 1	AT THE	
10		Francis bies	nann he	9	1205 Y	WK K	co. Lui	M-Tim	2100	23		
S	tate	31. Date filed (Month, Day, Year)	32. Registre	Signature	doon-Rand	.00_						



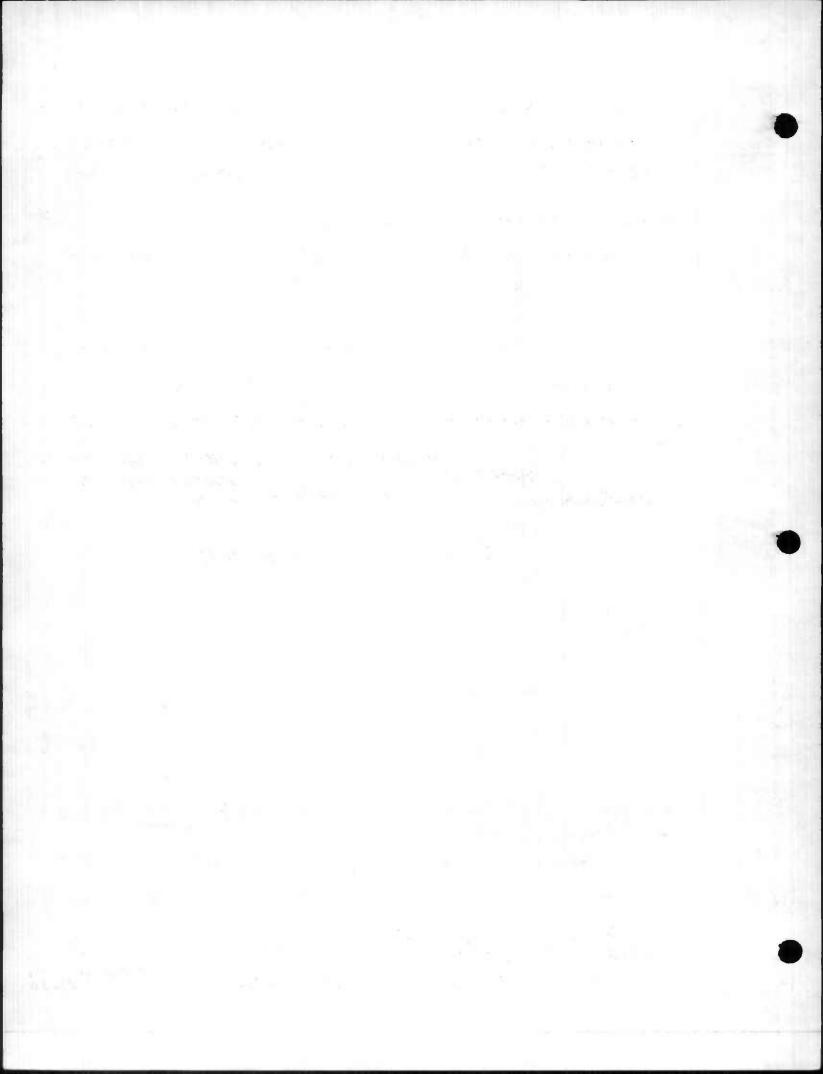
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month JUL 9 1998 **Physician** DOROTHEA HARRIET DOERFLER 12:43 AM /Medical 40 Facility Name (If not institution give street and number)
Saint Joseph Medical Center 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Towson If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Steta or Foreign Country) **Funeral** Days Months Hours 1 M 2 F 216-34-0285 62 MARYLAND Director APRIL 28, 1936 Usual Residence of Deceden the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 91990 U.S.A. 5 SENECA 1343 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Meritel Stetus Black, White, etc. 72 hours after 1 Never Merried 2 Merried Yes 2 2 DA Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE À 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "eny Injury or other treumatic event, the Magnes. Elementery/Secondery (0-12) College (1-4or 5+) 13+4 CLERK CO FINANCE MIA 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be JOHN SKAHILL VICLA BURMEISTER 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1343 · S. SENECA, RB. BALTO, MTS FERDINAN . E. DOERFLER ME 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 17/13/98 ELKRIDGE ,MD cemetery MEADOW RIDGE 22. Name end Address of Facility
HARTLEY 21. Signature of Funerel Service Licensee MILLER FUNETAL HOME - Oles BALTO MO 21234 Harford RD 7527 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. Let only one ceuse on sech line. Approximete Interval Between Onset end Deeth **Physician** PORTAL HYPERTENSION /Medical Immediate Cause (Final disease or condition resulting in death) Examiner CIRRHOSTS OF THE LIVER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Pod Due to (or as a consequence of) Box 68760. physiclar Physician/Medical Due to (or es e consequence of) 980 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 2 1 Yss 3 Probably 4 Unknown signed b Records. by 24b. Were eutopsy findings aveilable prior to Completed 24a. Was an autopsy performed? Deen completion of cause of death? page 2 hes certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury st Work? To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After i Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Msdical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier edical (Check only one) 29b. Signeture end title of certifier 29c. License number D30263 29d. Date signed (Month, Day, Year) Choo PRANCISS KHUO, WO M. D. COMBOLD COMBOLD TOWSON, MARYLAND 21204 32. Registra's Signature
Julia Davidson-Randall 31. Dete filed (Month, Dev. Year) State Registrar



State of Maryland / Department of Health and Mental Hygiene

	71	1. Decedent's Name (First, Middle, Last	t)				Death	2. Date of D	Reg. No.		3. Time of Death
Physici		Albert Otto	•					July	Day	Year 1998	
/Medic		4a. Facility Name (If not institution, give					4b. City, Town, o		11,	1998 nty of Death	11:45 pi
CXAIIII	iei	8800 Walther	Parkville Baltimore Co				oro Co				
Funeral		5. Social Security Number 6. Se	x 7. Age	205 (In yrs. last		ler 1 Year	If Under 24 Hr	s. 8. Date of B			place (State or Forei
Director		215-07-3505 Usual Residence of Decedent	X M 2□ F	85	Yrs. Months	s Days	Hours Mir	8-31-	-1912	Mar	yland
Now H		10a. Stete 10b. County		10c. Cily, T	own or Location					1	Od. Inside City Limi
a La	cto	Maryland Baltim	9					1 ☐ Yes 2 🕅 N			
or 28	Sire	10e. Streel end Number	10f. Zip Code					10g. Citizen o	of What Cour	nlry?	
238	ai	8800 Walther	r Blvd. #4205 21234					Uni	ted St	cates	
nd Mental Hygiene. merkad other than "natural", or items 23s or 28s-f show umetic event, the Mexical Examiner must be notified at	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 💆 Yes 2 □ No If Yes, Give Year or Dates:				Hispanic Origin? (en, Mexican, Pue Specify:	Specify Yes or N rto Ricen, etc.)	Io- 14. R B	lace - Americ lack, White, cify: Wh	
leaf in	Completed	15. Decedent's Edu	ucetion	10	6a. Decedent's Us	ual Occup	pation	-4.5	16b. Kind of	Business/Inc	dustry
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Hygien ther th	Co		Merc	chant	t			f Empl	oyed		
d oth	marked oth	17. Father's Name (First, Middle, Last)					ame (First, Midd		ame)		
Merka		Wenzel Eibner							Tauber		
nent of Health a int: If Nem 27 Is ury or other tra		19a. Informant's Name/Relationship (T)			19b. Mailing Addre						
		Mrs. Marcella D. E	inner / wi		3800 Walt of Disposition (N		RIAG. 1	4205 Ba	T	,MD n - City or To	21234
		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	ceme	etery, crematory or rkwood C	r other pla	,	7-15-98			Maryland
Departri Importa any Inju		21. Signature of Funeral Service Licens	•• Michael E.	Canapp			ess of Fecility ford Roa		ard J. F		
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	ner	disease or condition			NUM 8		s la	VCUESS	<u>/</u>		
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Inju Wo 1 □ Dory, office d at the tili on, In my co	26. Place of Doner: 4 □ Nursing ry at rk? Yes 2 □ No	23b. Di 1 24a. Wa per 1 24b. Wa per 1 28d. Describe 28d. Describe 28d. Location City or T	d tobacco use 2 No s an autopsy formed? Yes 2 No y one) sidence 6 C e how injury occ (Street and Num own, State) e cause(s) and e, date and place	24b. W. av. co of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 of 100 o	o the cause of deat bably 4 Unknow ere autopsy findings allable prior to mpletion of ceuse death? Yes 2 No No No No No No No No No No



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #7 Per FH Film G761 7-14-98RC Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month 1998 **Physician** twiN65 3:03 PM ANIEC /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner HOSPITAC HUNDER 1 Year Baltimore DACTIMURE JOHNS HOPKINS 7. Age (In yrs. last birthdey) 45 Yrs. If Under 24 Hrs. Dete of Birth (Month, Dey, 5. Social Security Number Funeral 12 M 2 F Months Days 216-52-6032 Usual Residence of Decedent Director 10 with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yee 2 No Baltimore Director 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 14. Rece - American I Bieck, White, etc. 21213 singte Funeral pernit. Pages 1 end 2 should be filed within 72 hours efter death Department of Haalth end Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No It Yes, specify Cuben, Mexican, Puerto Rican, etc.) American Indien 11 Maritel Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 200 No Specify. Specify: à 3 Widowed 4 □ Divorced ack Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) th contetion Orthone 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be EWINGS 10 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number City or Town, State, Zip Code) Doughter 20b. Place of Disposition (Neme of cemetery, cremetery or other place) Bettimore, Maryland
20c. Location - City or Town, State EWIMPS-20a. Method of Disposition 1 Buriei 2 □ Cremetion 3 □ Removel from State any injury or Cemetery Deltimore 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility

Left Muler P.C. Funeral Home

23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Home & Services Interval Between Onset and Deeth **Physician** /Medicai Immediate Cause (Fine) disease or condition resulting in deeth) Examiner Due to (or as e consequence ot) Examiner THEUMONIA ician and burial-transit law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): ETROVIRAL Division of Vital Records, P.O. Box 68760 physician LAFECTION Physician/Medical the Due to (or as a consequence of) use as t jo 23b. Did tobacco use contributa to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 □ Probably 4 Unknown 1 Yae 2 No 1RUS by 2 DRUG ABUSE 24e. Was en autopsy performed? 24b. Were eutopsy tindings eveilable prior to Completed completion of cause of death? certificata hes 1 ☐ Yes 2 ☐ No HLOHOL or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Npatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No this funeral 28d. Describe how Injury occurred 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b Time of 28c. Injury at Work? After t Certification: 1 Neturel 2 Accident 5 Pending investigation death. 1 Yes 2 No after death Director: Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tectory, office building, etc. (Specify) Mospital 24 hours a Funeral D 29a. Certifier (Check only one) 1 Certifying Physician: To the best ot my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner es stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated. Within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 RES -MAD HOUSE OFFICER 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

JOHNS HOPKINS HOSPITAL, 600 NOETH WOLFE STEET BALTIMORE, MARYLAND

Registrar

State

Buch - ...

SANJAY DESAL 31. Dete tiled (Month, Dey, Year)

JUL 14 1998 Julia Savidson Francese

32. Registrar's Signeture

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29c. License number

O.C.M.E.

KONUN 111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

JULY 13, 1998

State Registrar 29b. Signature end title of certifier

MARYDAMA

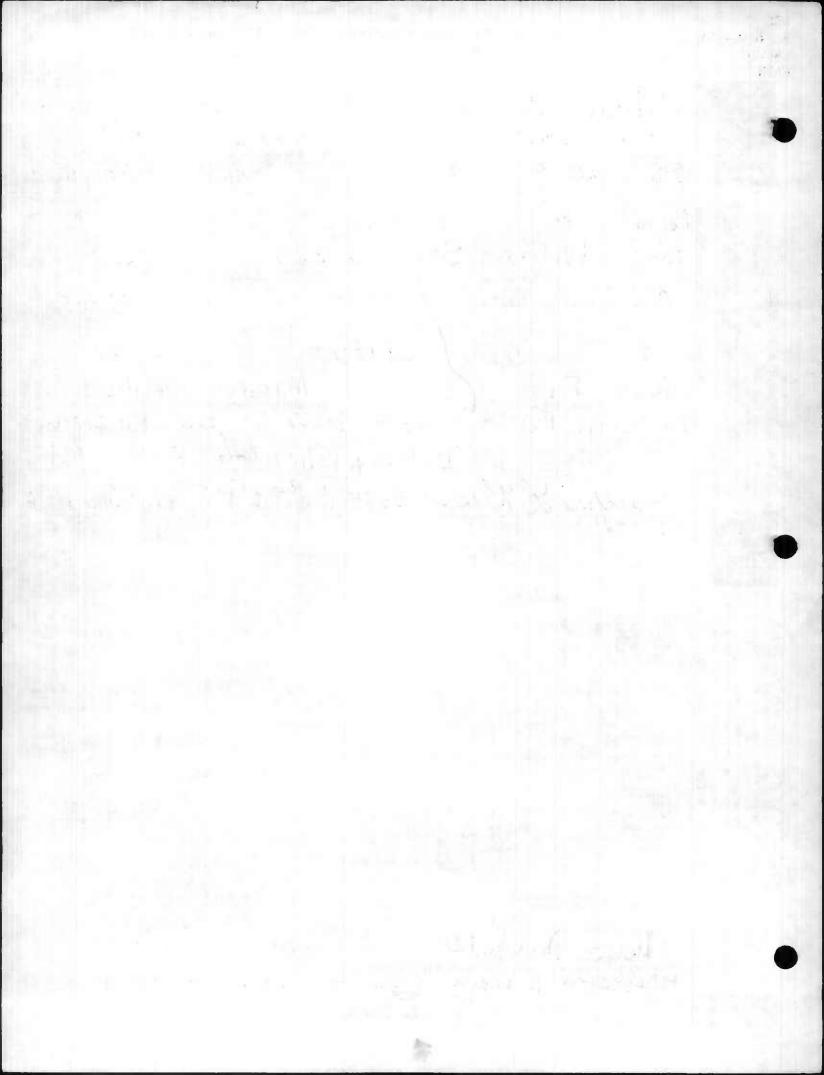
31. Date filed (Month, Day, Year)

Minte

JUL 14 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

e signature



State of Maryland / Department of Health and Mental Hygiene ?

2 No

600 North Wolfe Street Baltimore, Maryland

Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** .JIJI.Y 1998 FISHER Queen 7.11 a.m. DELILAH /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner BALTIMORE NA THE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 1□ M 2√ F 215-86-6283 47 Yrs. 08-29-50 Md **Director** Usuai Residence of Decedent the Marylend 10a, State 10b. Count 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at Md Baltimore XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2226 East Chase Street 21213 USA Funeral 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Deles: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorcad Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If fem 27 is marked other than * any injury or other traumatic event, in the any injury or other traumatic event, in the Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade Nursing Assistant Belair Convalescent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marks Alice James Baines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2226 E. Chase Street Baltimore, Md. 21213 Andrew Queen, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. Cem. 07-17-98 Randallstown, Md. 2. Name and Address of Facility Baltimore, Maryland 21202 ana WM.C.March FH 1101 E. North Avenue Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onsel and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Fungal Sepsis 10 days Examiner Due to (or as a consequence of) Physician/Medical Examiner Backenal Sepsis 23 days physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Abult Respiratory Distress Syndrome Due to (or as a consequence of): 23 days Division of Vital Records, P.O. Box 68760, 98 unknown attending p Chronic myclomonocytic Levkenia Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. signed by the a 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Above the Knee Amputation on Right, Cardennyopath \$ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed Diabetes Mellitis, Hypertension certificate has b irector, page 2 s 1 Yes 25. Was cese referred to medicel examiner? Be 28. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? al or Attending P s after death. I Director: After i d in by the funera 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Yeer) 29b. Signeture end title of cartifier 29c. License number RES - 000 July 11, 1998 MD House OFFicer

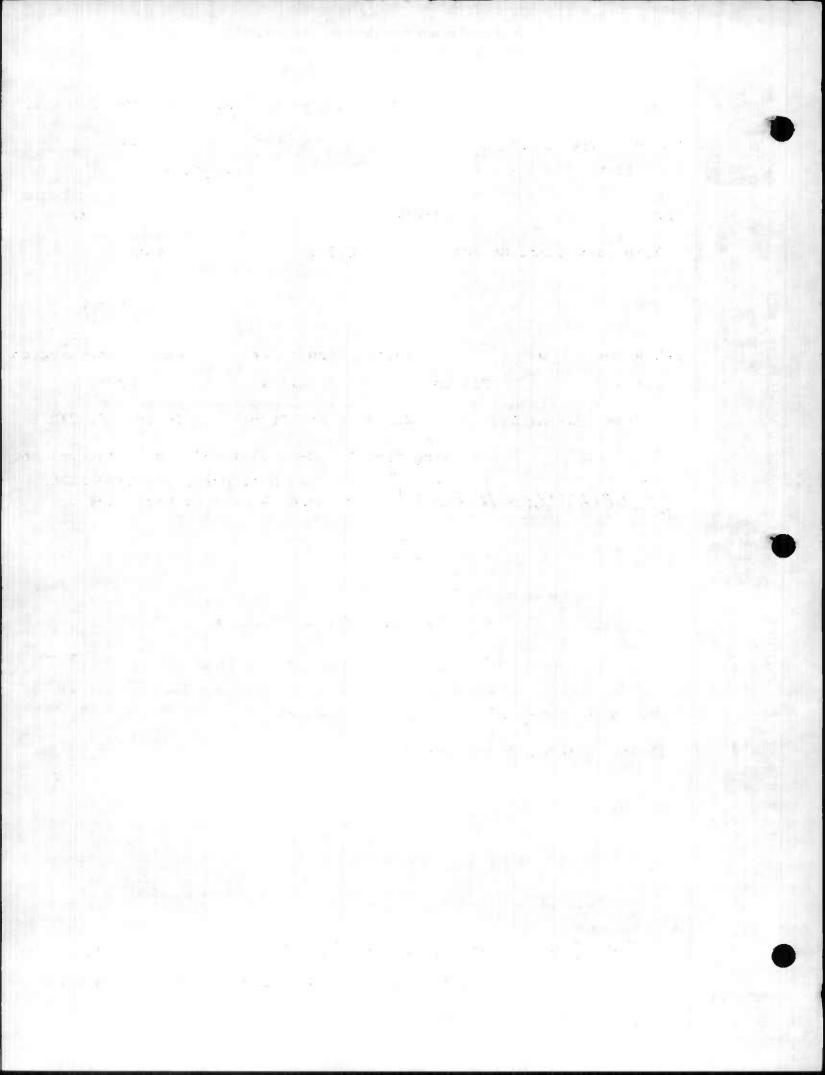
Registrar

31. Date filed (Month, Day, Year) JUL 14 1998

Todd Ellerin

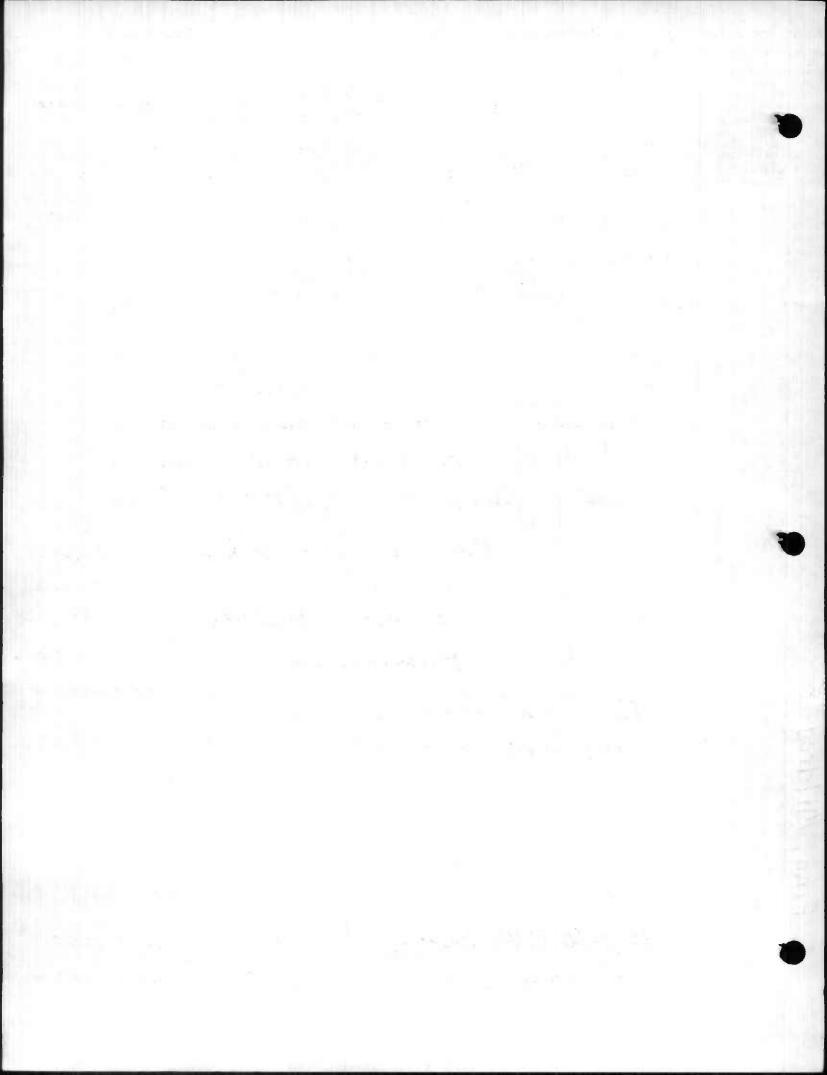
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

The Johns Hopking Hospital 32 Registrar's Signature gitia Devidor Bandall



State of Maryland / Department of Health and Mental Hygiene

					ary idira 7	Certificate of			eg. No.	2.	1495	
	Phys	ician	1. Decedent's Name (First, Middla, Le	st)				2. Dete of Dee	th Dey	Yeer	3. Time of Dec	
		dical		MMA FIN	V N			July	6,1	998	11:181	M
	Exar	niner	4e. Fecility Neme (If not institution, giv		T		4b. City, Town, or L		4c. County			
	-		FALLSTON GENER 5. Social Security Number 6. S		IAL e (In yrs. lest bi	inthday) If Under 1 Yes	FALLSTO ar If Under 24 Hrs.	8. Date of Birth		FORI		
	Funer Direct	_		□M 2KDXF	75	Yrs. Months Dey		Nov. 11	Year)	MARY	lece (State or Fo try) LAND	некуп
	Man Mand		10e. Stete 10b. County		10c. City, Tov	n or Location				1	0d. inside City Li	imits
	Man Am	to	MD. BALTIMO	DRE	wH1T	E HALL					1□Yes XX	No
	with the Marylar a or 28a-f show be notified at	Director	10e. Straat end Number			10f. Zip Code		1	0g. Citizen of W	hat Coun	try?	
	seath w ma 23a mant J	Funeral	5114 MEADOWVIE			21161			U.S.A			
	lar des		11. Meritei Stetus	12. Wes Decedent E Armed Forces?		13. Was Decedent of if Yes, specify Cu	f Hispanic Origin? (Spuben, Mexicen, Puerto	pecify Yes or No- Rican, etc.)		- Americ k, White,	an Indien, etc.	
	0020 hours after unal', or its al Examina	by F	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No if Yas, Give Yeer or Detes:	10	1 □ Yes 2,□YN	o Specify:		Specify:	WHITI	c	
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	21215-0020 d within 72 hours at piens	Completed	(Specify only highest gre Elementery/Secondery (0-12)	College (1-4or 5-	+)	Decedent's Usuei Occ (Give kind of work don life. DO NOT use ratio	ned)	king				
		ဝိ	8 17. Father's Neme (First, Middle, Lest)		Н	OUSEWIFE	10. Mathada Naw	o (Final Adiable)	DOME			
	d be d be d of ceve	Be	HARRY BURNUP				18. Mother's Nem			9)		
	Maryland 12 should be tile h and Mental Hy 7 is merked othe manuatic event	J.	19e. informent's Name/Raletionship (Гуре, Print)	19	o. Mailing Address (Stre	CATHER et and Number or Ru			Stete, Zip	Code)	
	- 5 % N L		MARLA SAWYER/DAUGH	ITER	51	14 MEADOWVI	EW DRIVE.	WHITE HA	LL. MARY	LAND	21161	
	B - 1 1 6		20e. Method of Disposition XX Buriel 2 ☐ Cremetion 3 ☐	Removel from State	20b. Place 0	of Disposition (Name of ary, crametory or other p	1		20c. Location -			
1	altimo nil. Page artment ortant: if injury or		4 □ Donetion 5 □ Other (Specify	y)	ST. S	TANISLAUS C	EMETERY 7	/10/98	BALTIMO	RE, MI).	
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1			23a. Pert1. Enter the disease, or comp	X. Laur	Æ.	1901 FASTE	ILER INC. RN AVENUE	BALTIMO	RF MD	21231		
	Physicia		shock, or heart feilure. List only	one ceusa on each line	e.	not enter the mode of or	ying, such es ceralec	or respiretory erri	est,		Approximete intervei Batweei Onset end Deat	n th
	/Medica	al	Immediete Ceuse (Final disease or condition	C	luo	mic Re	mal 7	alex	5-8		2-416	10
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	ed sit	ulne		b	Uno	sysi !	5			1	2 wee	les
	68760, tificate be axecuted g physician and as the bunal-transit	Physician/Medical Examiner	Sequentially list conditions, if erry, leading to immediate ceuse. Enter Underlying Ceusa (Disease or injury	D	Dua to for es e	consequence of):	1110	105		; 	2 yea 2 wee > 20 y	les.
	68760, ficate be ax physician is the burial	call	thet initiated events							+	7 - 0 0	
		Medi	resulting in daath) Lest		i /	2013544	1 50-				21040	en
	Box Bath cert attanding for use	lan	171	d	119	justin	ar -			1		
M	the a	ysic	Pert ii. Other algnificant conditions co	ontributing to death but	t net resulting	n the underlying cause	given In Pert I.	23b. Did to	bacco uss con	tributa to	the cause of de	eath?
	I Records, P.O. BOX The law requires that the death cer ste has been signed by the attandir page 2 should be detached for use	by Ph	Pengh	eral l	orac	vonta	I seace	1 □ Y	es 2 No	3 Prob	ably 4 Unk	LOWN
p:	Records, e law requires t has been signe ge 2 should be		P. W/	1 >		0.77		24a. Wes e	n autopsy		era autopsy findir	ngs
re	Heco e law re has be	Completed	- Jen ju	rai	ven	of the or	7	periori	ned r	cor	mpletion of cause death?	0
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	of Vital Physician: Th this certificate ral director, pag	B	25. Wes cese referred to medicel exeminar?	Lih-l				th (Check only on	ө)			
M	G & X	-T	1 ☐ Yes 2 ☑ No 27. Manner of Deeth	Hospitel: 1 Inpatien 28a. Dete of Injury		Dipatient 3L DOA		ome 5 Reside)	
	VISION Attending I r death. sector: After by the funer	tlon	1 ☑Naturai 5 ☐ Pending 2 ☐ Accidant investigation	(Month, Day		Time of 28c. inj	ork? □ Yes 2 □ No	28d. Describe ho	w injury occurre	ea.		
C.	DIVISIO Il or Attendii after death. Director: A	Certification:	3 Sulcide 6 Could not be datarminad	28a. Place of tnjur	ry - At homa, fa	arm, street, factory, office		28f. Location (St	reet end Numbe	or or Rura	Route Number,	
< 0	Ta affe in led in	Cert	Tomade	building, afc.	. (Эреспу)			City or Towr	1, 51616)			
11	DIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	edical	(Unick only 2 Madical Exam	Mnar: On the basis of e	examination ar	a, daath occurred et the id/or investigetion, in my	tima, data and place, opinion, daath occur	and due to the ce	euse(s) end mar ata and place, a	nar as at	ated. the cause(s)	
	To the Ho within 24 I To the Fu	Med	one) 290. Signature and title of dentities	end menner stet	ed.		nse number		9d. Dete signed			
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	11		30. Name end eddress of person who o	completed ceusa of da	ath (Itam 23e)	(Type, Print)			1 9	-1	1110	
	26			LARAU, "	4.0.	(Type, Print) 17/6 HARF	ORD RD	Room 10	6 FALL	STOR	1 MD21	1047
	Regis	State	31. Dete filed (Month, Dey, Year)	32. Registrer	r's Signature	Mandale						



Months

10f. Zip Code

SHIRLEY FRIZZLE State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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fine.	- 6	1	0

Physician	١
/Medical	١
Evamina	

Shirley E. Frizzle

2. Date of Death JULY

3. Time of Death 8:25P.M.

Director

Funeral

by

Completed

2

Examiner

Physician/Medical

by

Completed

Certification:

edical

4a Facility Name (If not Institution, give street and number) 5263 CORDELIA AVE

1 Decedent's Name (First, Middle, Last)

4b. City, Town, or Location of Death BALTIMORE

03, 1998

4c. County of Death N/A

Funeral Director

217 24 7033 Usual Residence of Decedent 10a State 10b. County

5. Social Security Number

7. Age (fn yrs. last birthday) 1□ M 20 F Yrs. 70

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Days Hours July 2, 1928

 Birthplace (State or Foreign Country) Maryland

than "natural", or items 23s or the Medical Examiner must be 7

Department of Health and 2 should be filed within 72 hours after Department of Health and Mental Hypines. Department if them 27 is marked other than "natural; or its may injury or other traumatic event, the Medical Examina any injury or other traumatic event, the Medical Examina

the Maryta

Maryland

10c. City, Town or Location Baltimore

10d. inside City Limits 15 Yes 2□ No

10e. Street and Number

5263 Cordelia Avenue

21215

10g. Citizen of What Country? II.S.

11. Marital Status

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Yes 200No Specify:

14. Race - American Indian, Black, White, atc. Specify. White

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 8th

Homemaker

Own Home 18. Mother's Name (First, Middle, Maiden Surname)

17. Father's Name (First, Middle, Last)

George W. Brogan

Viola Simms

Date

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 Marshall Street

Baltimore, Maryland 21230 20c. Location - City or Town, State

Sharon Sauer / daughter 20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery

7/7/98 Baltimore, Maryland

Kac

Xaris

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

22. Name and Addrass of Facility 4001 Ritchie Highway

Gonce Funeral Home P.A. Baltimore, Md. 21225

Physician /Medical Examiner

physician end the bunal-transit

50 987 Po

by the e

signed b

certificate ha

funeral

ector: /

or Attending Physician: after death. Director: After this certifice

24 hours

within 2 To the

3

The law requires that the death certificate be asscuted

Box 68760.

o

Division of Vital Records,

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting In death)

Colon Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

26. Place of Death (Check only ona)

23b. Did tobacco use contributa to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown

Chronic Obstructive Polomorary Disease Jehizaphrenia

partial

1 Tes

24b. Wara autopsy findings available prior to completion of cause of daath? 1 THE 2 NO

Onset and Death

25. Was cesa raferred to medical examiner? Be 0 1 Yas 2 No

Hospital.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Tima of

28c. Injury at Work?

Other: 4 Nursing Homa 5 X Residence 6 Other (Specify) 28d. Dascribe how Injury occurred

27. Manner of Death 1 Natural 2 Accident

5 Panding investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

29a, Cartifian (Check only one)

3 Suicide

4 Homicide

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) JULY 4,1998

lutero

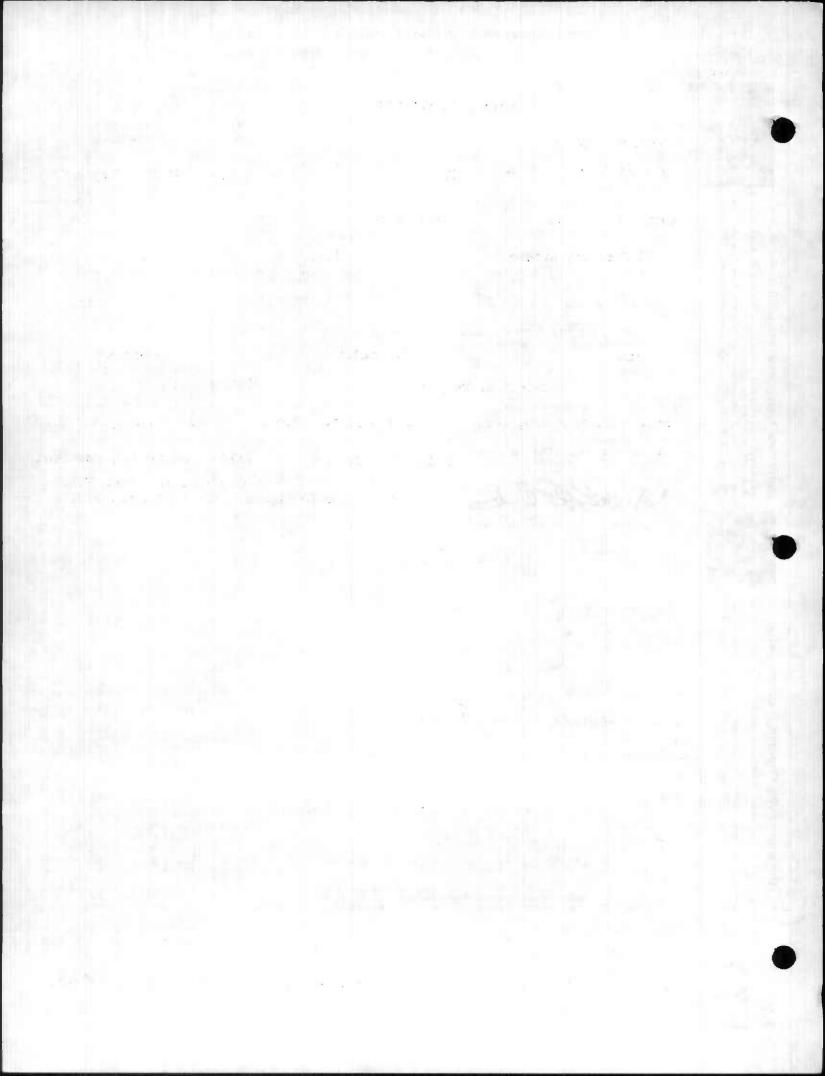
O.C.M.E.

30. Nama and addrass of person who simplated cause of death (Itam 23a) (Type, Print)

Vennis 31. Data filad (Month, Day, Year) JUL 141998

111 Penn Street, Baltimore, Maryland 21201 no 32. Registrar's Strature

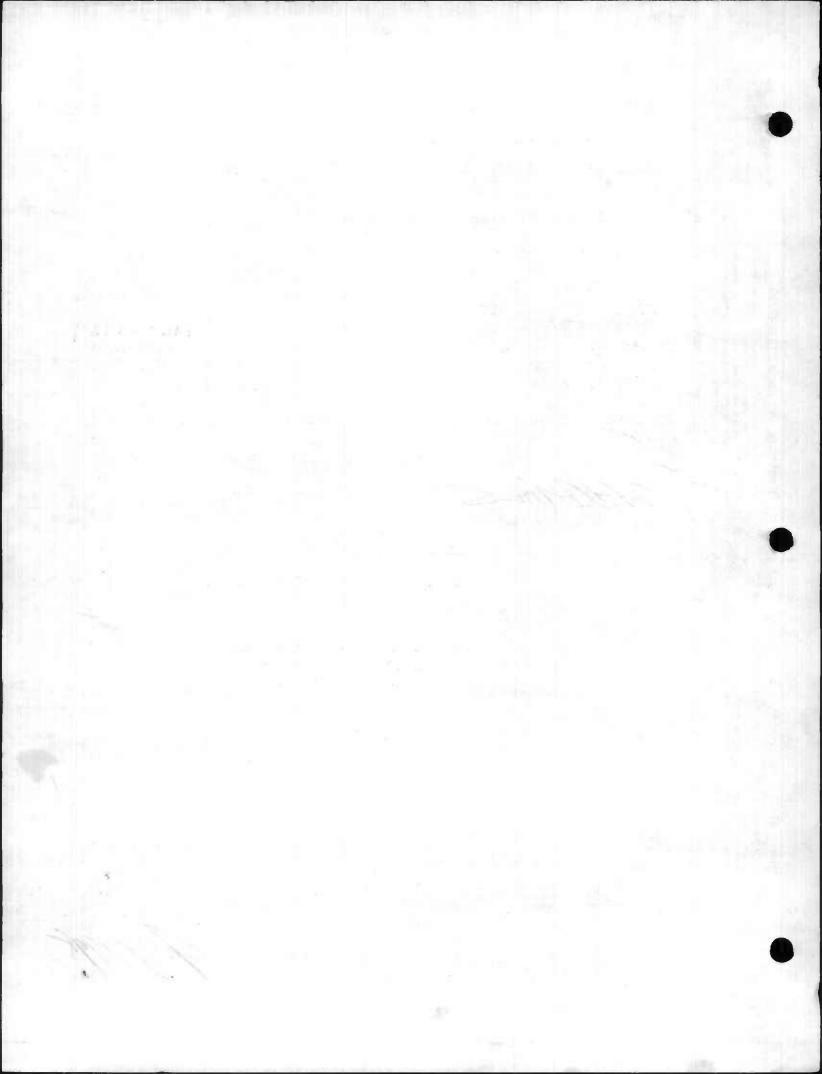
State Registrar



State of Maryland / Department of Health and Mental Hygiene ()

I	tems:23b,24a,25,26,27 p	er M.D G-761 7/14/9	⁹⁸ Certificate o	f Death		Reg. No.	L.	1491
Dhusisian	1. Decedent's Nama (First, Middla, La	-		2. Data of De Month	ath Day	Year	3. Tima of Death	
Physician Medical/	- David Honor				1		98	11:32A
Examiner	4a Facility Nama (If not institution, given	•	tor	4b. City, Town, or Lo		4c. County		2
Funeral	Saint Joseph 5. Social Security Number 6.5	Sax 7. Aga (In yrs. la	ast birthday) If Under 1 Yas	r If Under 24 Hrs.				
Director	019-30-5111 Usual Residence of Decedant	1 DX 2 DF 58	Yrs. Months Day	s Hours Min.	Mar. 1	2,1940	Mass	ace (Stata or Form ry) achuset
ahow	10a. Stata 10b. County	10c. City	, Town or Location				10	d. Inside City Lim
death with the Maryland ms 23s or 28s-f show f.ms.t.be.notfied.st neral Director	VA Prince	William Woodbridge						1 ☐ Yes 2
or 28	10e. Street and Number		10f. Zip Code			10g. Citizen of W	What Country?	
23a	12104 Winona	Drive	221			U.S.A	_	
	11. Marital Status 1 Nevar Married Married 3 Widowed 4 Divorced	12. Was Decedant Evar in U,S Armed Forcas? 1 Yas, Giva Yaar or Datas:	S. 13. Was Decedent of If Yas, specify Co	Hispanic Origin? (Sp ban, Mexican, Puarto Specify:	ecify Yas or No Rican, atc.)	Black	- America k, Whita, a : Whi	itc.
2 hou	15. Decedant's E	ducation	16a. Decedent's Usual Occ	upation		16b. Kind of Bu	sinass/Ind	ustor
be filed within 72 hours after tal Hygiene. I other than "natural", or its event, the Medical Examin Be Completed by Fu	(Specify only highast gra Elamantary/Secondary (0-12)	Collega (1-4or 5+)	16a. Decedent's Usual Occ (Giva kind of work don lifa. DO NOT use reti Retired O		ing	16b. Kind of Bu		- 1
	17. Father's Name (First, Middla, Last Clyde V. Lew			18. Mother's Nem	ha Zie		a)	
and Menia marke	19a. Informant's Name/Ralationship (Type, Print)	19b. Maiting Address (Stre	et and Number or Run	al Routa Numb	er, City or Town,		
other tr	Mrs. Betty Fa		12104 Win	ona Dr.W	oodbri			
	20a. Mathod of Disposition 1 Wirial 2 Cramation 3 C 4 Donation 5 Other (Special	Ramoval from Stata	ace of Disposition (Nama of matery, cremetory or other p antico Nati	1	Data	20c. Location - 0		
permit. Pages Department of Important: If is any Injury or once.	21, Signature of Funaral Sarvice Light		22. Nama and Add		ary ra	,1330		ginia
pemit. Depart Import any inj once.	12/2014	Mas	13318	castle F	n Rd.	Woodbr	idge	
	23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only	plications that causad tha death one cause on each line.	. Do not entar the mode of d	ying, such as cardiac	or raspiratory a	mast,		Approximata Intarvat Betwee Onset and Dea
Physician /Medical	Immediata Causa (Final	CORONARY	ARTERY DISE	ASE (rec	urrent)	1	2 year
Examiner	disease or condition resulting in death)	PREVIOUS	as e consequence of): CORONARY AR	TERY BYP	ASS SU	RGERY	1	2 year
be executed sician and burial-transit	Sequantially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Disease or Injury that initiated evants	ACUTE MYOCARDIAL INFARCTION					t	2 days
the the	rasunting in death) Last	CORONARY of and VENTRI	RY (re-done)			2 hour		
eath certific attending p for use as		CARDIAC AN						
by the at ached for a hysici	Part II. Other significant conditions of				23b. Did	tobacco una con	tribute to	
ed by detacl					10	Yes 2□ No	3 Prob	ably XX Uni
requires ten significant pould be						an autopsy rmed?	ava	re autopsy findi ilable prior to appletion of caus leath?
The law ate has b page 2 s					40	- 177 N		
certificate rector, pa	25. Was casa rafarred to medical			OS Diver of Door	1	Yas 2 No]Yas 2□ No
hysician: his certific I director, To Be	axaminer?	Hospital: X 10 Inpatient 2 6	ER/Outpatient 3 DOA	26. Place of Deat Other: 4 Nursing Ho		dence 6 □Othe	er (Specifi	·)
		28a. Date of Injury (Month, Day Year)	28b. Time of Injury 28c. In W	jury at fork?		how injury occurr		•
2 4 4 E	2 Accident Invastigetio 3 Suicide 6 Could not b datarmined	e Con Diago of Laive, At hos	ma, ferm, street, factory, offic	□ Yes 2□ No e	28f. Location (City or To	cation (Street and Number or Rural Route Number y or Town, Stete)		
Hospi 24 hour Funer Hely fill		nyalclan: To the best of my known in the basis of axamination and manner stated.						
To the comple		100 _		nse number 3 0 4 5		29d Date offred	(Month, E	My. Year
	30. Name and address of parson who STEPHEN D.LING	comptated causa of daath (Item	23a) (Type, Print)		SON, MA	RYLAND	24	04
State	31. Data filed (Month, Day, Year)	32. Flegistrar's Signat						
Registrar	JUL 14 199	20	of and hastered					

DHMH 16 Ray 6/95



Months

6:50am

Clarence

1. Decedent's Name (First, Middle, Last)

Grant

7. Age (In yrs. lest birthdey)

2. Date of Death July

Rea. No

Day 12,

3. Time of Death Year 98

4a Facility Name (If not institution, give street end number)

Future Care @ Canton Harbor

Baltimore

4c. County of Deeth

Funeral Director

with the Maryla

72 hours after

filled within Hygiane.

should be h and Montal I is marked of

Baltimore,

permit. Pages 1 and 2 at Department of Health and Important: If Nem 27 is n any injury or other traus

Physician

/Medical

Examiner

attending physician and for use as the bunal-transit

ed by the a

signed by to

peeu

has

certificate

: After this certifica e funeral director, r

Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certificately filled in by the funeral director,

To the Vithin 2

98

The law requires that the death certificate be executed

Records, P.O. Box 68760

Division of Vital

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

edicai pletely

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Usual Residence of Decedent 10a State

10c. City. Town or Location NA

8. Date of Birth (Month, Day, Year) 03-02-23 Days Hours

4b. City, Town, or Location of Death

Birthplace (State or Foreign Country)

5. Social Security Number

217-18-3250

10b. County

MD

Baltimore

Yrs.

10d. Inside City Limits XXYes 2 No

10e. Street and Number

1004 East 20th Street

№ М 2□ F

10f. Zip Code 21218 10g. Citizen of What Country? USA

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🐼 No If Yes, Give Yeer or Detes:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2X No Specify:

14. Race - American Indian. Biack, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Elementery/Secondary (0-12)

Taylor

Laborer

12th Grade 17. Father'a Name (First, Middle, Last)

> Grant John

18. Mother's Name (First, Middle, Maiden Sumeme)

Johnson

19e. Informant's Name/Reletionship (Type, Print)

19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)212181004 E. 20th Street Baltimore, Maryland

Grant

20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from Stete 20b. Piaca of Disposition (Name of cametery, cremetory or other place)

20c. Location - City or Town, State

4 ☐ Donation 5 ☐ Other (Specify)

Loudon Pk. Cem. 07-16-98 22. Name and Address of Facility

Baltimore Co, Md.

21. Signature of Funeral Service Licensee

Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death)

ACUTE MYOCARDIAL

INFARCTION

30 MIN

Due to (or as a consequence of): ACUTE CORONARY ANTERY

OSCLUSION 30 MIN

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

CORONARY Due to (or es a consequence of)

23a. Part T. Enter the disease of complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as e consequence of): ATHENOSCLENOSIS

ZOYEARS

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

STENOSIS LUMBAR

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

1 ☐ Yes 2 No

25. Was case referred to medical examiner? examiner?

Hospital: 5 Pending

Investigation

6 ☐ Could not be

28a. Date of Injury (Month, Dey Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

27. Manner of Death

2 Accident

4 ☐ Homicide

3 Suicide

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29b. Signature and title of certified

29c. License number gele M.A.DO 7316 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

auch ?. 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

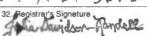
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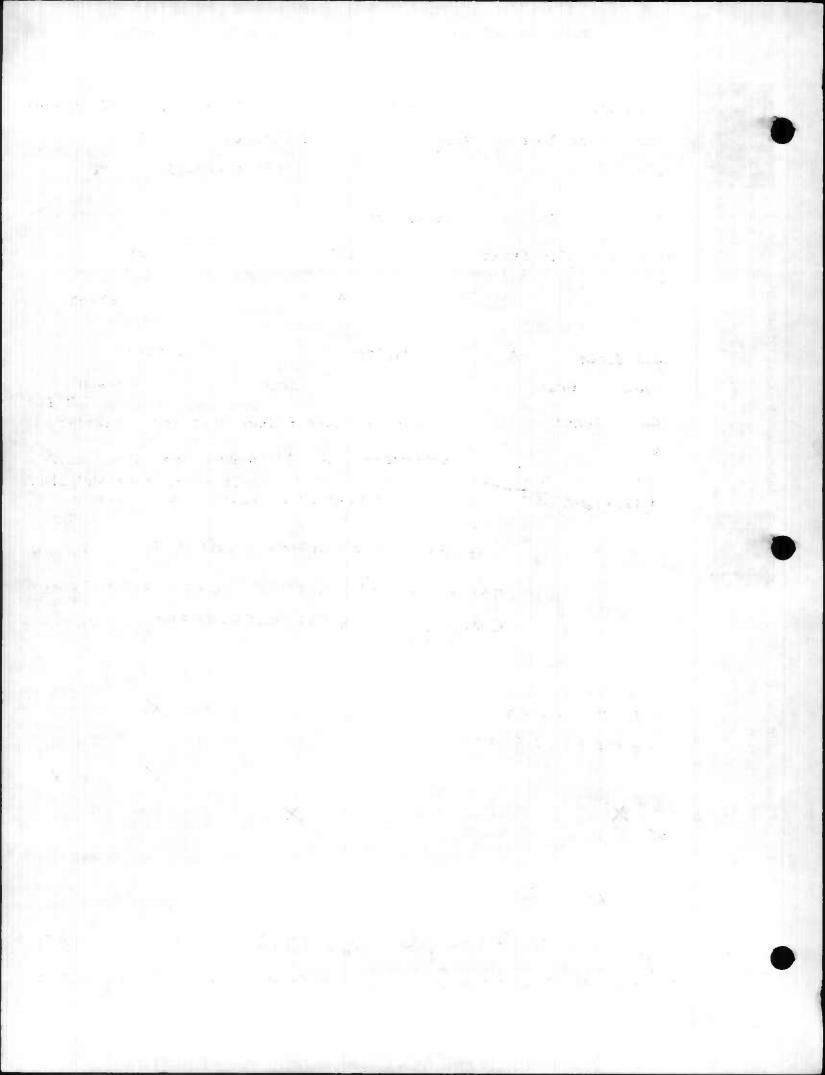
301 ST. PAUL PLACE BALTIMENE MD. 21202 TOSEPH D. NOTARANCELO M.D.

State Registrar

31. Date filed (Month, Dey, Yeer)

JUL 1 4 1998

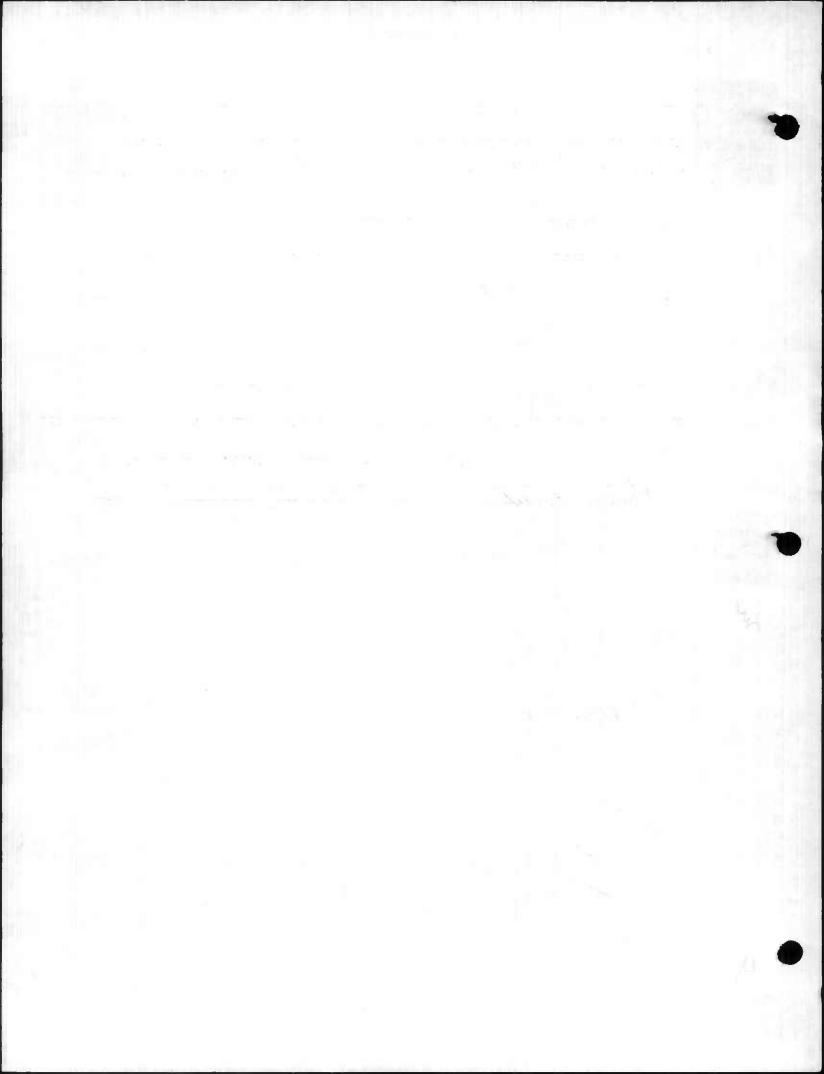




State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dev **Physician** Month ETHEL CONZALEZ JULY 08, 1998 4:45 PM /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Deeth **Examiner** LORIEN NURSING & REHABILITATION CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplece (Stete or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Year) **Funeral** 1□M 2\ F Days 88 219-16-9235 Yrs. Director 06/28/1910 MARYLAND Usual Residence of Decadant the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Yes 2 No Director COLUMBIA HOWARD 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 items 23a 6336 CEDAR LANE 21044 death Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yas, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Reca - American Indian, Black, Whita, atc. should be filed within 72 hours efter and Mental Hygiene.
marked other than "naturel", or ite 1 □ Navar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: by Specify: WHITE 3 Widowed 4 □ Divorced Completed traumatic event, the Medical 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Spacify only highest grede complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER 8 OWN HOME permit. Pages 1 and 2 should be filed.
Department of health and Mental Hygin Important: If item 27 is marked any injury or other permanents. 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumema) Be WILLIAM OGLE EVA KINSEY 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Addrass (Streat end Number or Rural Route Number, City or Town, State, Zip Code) 180 FOX MEADOW LANE, ORCHARD PARK, NEW YORK 14127 KENNETH HESTERBERG/NEPHEW 20b. Place of Disposition (Neme of cemetary, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEMETERY 7/11/98 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility STERLING ASHTON FUNERAL HOME, INC. tack tulk 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each lina. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final Element ic 340011 diseasa or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as e consequence of): Box 68760 Dua to (or es e consequença of): The law requires that the death certificate P.O. Part II. Other algorificant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? lichetes 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ Completed 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to peen completion of cause of death? page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate of Vital Be director. 25. Was case refarred to mindical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? After Division Attanding 5 Panding investigation 1 Natural To the Hospital or Attandin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the ful 2 Accident 6 Could not be determined 3 Suicide 28e. Piace of Injury - At home, farm, straat, lectory, office building, atc. (Specify) 28f. Location (Straet end Number or Rurel Route Number, City or Town, Stata) 4 Homleida Lactifying Phyeician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and menner as stated.

2 Madical Examiner: On the best of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier edical (Check only one 29b. Signature and the of contra 29c. Licansa number 29d. Data signad (Month, Dey, Year) 30. Name end eddress of person who complated sause of death (Item 23a) (Typa, Print) Colon 61a, May long (- G1 31. Data filed (Month, Dey, Year) 32. Registrar's Signature State JUL 141998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10 /Medical City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) . 4c. County of Deeth Examiner comone N/A If Under 1 Year 5 Sociel Security Number Birthplece (State or Foreign Country) Funeral Months M 2DF Deys 218 36 2558 Director Maryland Usuei Residence of Decedeni with the Marylend 10e State 10h County 10c, City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Examiner, must be nottled at 1 ☐ Yes 20 No Directo Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 20 Ballman Court U.S. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11 Maritel Stetus 14. Race - American Indian. Bleck, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health end Mentel Hygiene. If them 27 is marked other than "natural", or itse 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest g ede completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) Technician Cadillac Amusements 12th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Sarah Edna Lewis William S. Golt 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Sarah E. McDonald / mother 20 Ballman Court Baltimore, Maryland 21225 or other 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ₺ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 7/13/98 Baltimore, Maryland Injury o Cedar Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Spec fy) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete interval Between Onset end Deeth **Physician** failure /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner that the death certificate be executed physician end s the burial-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest P.O. Box 68760, Physician/Medical 950 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by t 2 No 3 Probably 4 Unknown Records, p 24b. Were autopsy findings evelleble prior to completion of cause of death? Completed 24e. Wes en eutopsy peen has **pege 2** 1 Yes 2 N No 1 ☐ Yes 2 No certificate Division of Vital Attending Physician: 25. Wes case referred to medicel examiner? Be 26. Piece of Death (Check only one) 2ER/Outpatient 3□ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 20 No 1 Inpatient this funeral Dete of Injury (Month, Dev Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. injury et Work? After Naturei 5 Pending A 1 Yes 2 No Accident investigation 24 hours ofter deat Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number City or Town, Stete) 4 Homicide 24 hours effer Certifying Pt ysician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical To the I within 2 29b. Signeture and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) (Item 23a) (Type, Print) 30. Name end eddress of person -, BALTIMORE MY 31. Dete filed (Month, Dey, State Registrar

